

HEALTH CARE POWER OF ATTORNEY OF JANE DOE

I, JANE DOE, a resident of _____, do hereby create this Health Care Power of Attorney. I revoke all health care powers of attorney I have previously executed.

ARTICLE ONE: AGENT

I appoint JOHN DOE as my Health Care Agent to exercise the powers described below.

Address: _____

Phone: _____

If JOHN DOE fails to serve, I appoint the following to serve as successor Health Care Agent successively, in the order named:

First Successor Agent

Name: _____

Address: _____

Phone: _____

Second Successor Agent

Name: _____

Address: _____

Phone: _____

ARTICLE TWO: EFFECTIVENESS AND DURATION

This Health Care Power of Attorney shall become effective when, and only when, I cannot make my own health care decisions. Once effective, this Health Care Power of Attorney shall remain effective until my death, or until such time as I regain the ability to make my own health care choices. I may revoke this Health Care Power of Attorney by providing written notice to my Agent.

ARTICLE THREE: POWERS GRANTED

I give my Health Care Agent power to make all decisions for me about my healthcare. My Agent's power shall not be limited to but shall include the power to:

1. Make all decisions for me about my healthcare.
2. Direct the withholding or withdrawal of life-prolonging treatment.
3. Consent, refuse, or withdraw consent to any care of whatever nature, procedure or treatment.

4. Authorize participation in research related to my health.
5. Employ and discharge medical personnel.
6. Select a facility for my treatment, rehabilitation, convalescence, or hospice care and make all necessary arrangements therein for my well-being.
7. Access all my medical information and medical records from any and all my health providers.
8. Take legal action on my behalf.
9. Consent to the use and administration of any pain-relieving drugs and pain-relieving surgical procedures my Health Care Agent believes may provide comfort to me.

ARTICLE FOUR: GUARDIAN OF MY PERSON AND MY ESTATE

If I become in need of a Guardian, I nominate my Health Care Agent to serve as the Guardian of my Person and my Estate.

ARTICLE FIVE: ADDITIONAL PROVISIONS

I authorized any health provider of mine to release any medical records, including those protected by HIPAA, to my Health Care Agent. I release from all liability any health provider that provides my medical information to my Health Care Agent. I acknowledge that once disclosed, any information that would otherwise be protected under HIPAA will not be protected.

My Agent shall not be liable to me or to my estate for any loss that may result from acts that were performed by my Health Care Agent in good faith.

My agent shall be entitled to reasonable compensation and to reimbursement for reasonable expenses incurred as a result of carrying out the provisions under this Durable Power of Attorney.

No person or entity who relies on the authority of my Health Care Agent under this Health Care Power of Attorney shall incur any liability to my estate, my personal representative, or to me.

JANE DOE, Principal

Date

First Witness Signature

Second Witness Signature

First Witness Printed Name

Second Witness Printed Name

Date

Date

First Witness Address

Second Witness Address

First Witness City, State, Zip

Second Witness City, State, Zip

Subscribed, sworn to and acknowledged before me by JANE DOE, _____
(First Witness), and _____, (Second Witness) this ____ day
of _____, 20 _____

Notary Public

My commission expires on: _____

(Seal)