DURABLE POWER OF ATTORNEY FOR HEALTHCARE

Declaration made this _______ day of ____________________________ (month), 20 _______
I, ____ having the capacity to make healthcare decisions, willfully and voluntarily wish to identify the person and/or people I have chosen to represent me if I temporarily or permanently lose the capacity to make healthcare decisions for myself. If I regain that capacity, I wish to reassert my own right to make decisions pertaining to the treatment that I receive. 1a. I appoint as my PRIMARY Healthcare Representative:

Name: ____

Address:____
____

Email: _____________________________Phone(s):___________________________________

Relationship to me: ____

1b. If the above named individual is not available to act on my behalf, I appoint the following person as my ALTERNATE Healthcare Representative:

Name: _____________________________________

Address:____
____

Email: _____________________________Phone(s):___________________________________

Relationship to me:_________________

1c. If neither of the above-named individuals is available to represent me, I authorize my healthcare providers to contact, in order, the following substitute decision-makers as approved for this purpose by the jurisdiction in which I am receiving care i.e. my spouse or domestic partner, my adult children, my parents; and/or my adult brothers and sisters.

Name: ________________________________ Relationship__________________________

Phone _________________________________E-mail:_______________________________

Name: ________________________________ Relationship__________________________

Phone ________________________________E-mail:______________________

1d. I do not want the following people to participate in planning my end-of-life care.
Name /Relationship ____
Namr/Relationship____
Name /Relationship ____

2. I grant my representative(s) complete authority to make decisions consistent with my stated wishes with regard to starting, refusing, stopping, and/or removing all forms of medical, mechanical, and surgical intervention.

3. If my healthcare representative is unsure about what to decide, I want him or her to please (check ONE): _______ ignore such doubts and act on my Living Will as written OR _______ make the best decision he or she can in the face of uncertainty OR _______ discuss the situation with my doctor, family members, and/or spiritual advisors named below, then use his or her best judgment and after considering their opinions.
Doctor'sName____
Family Members Name: ____
Spiritual Advisor Name: ____

4. I Do _______ Do Not _______ (choose ONE) want this decision-making authority to extend to decisions that are made after my death with regard to autopsy, organ donation, and the handling of my remains.

5. I instruct my healthcare providers to release to my representative(s) any information about my medical condition, possible treatments, and prognosis pursuant to the attached HIPAA authorization for release of information.

6. This agreement supersedes and replaces any and all formerly executed Durable Power of Attorney Healthcare documents.

Sign only in the presence of witnesses: Signed this ___day in the month of __________ , 20 __
Signature: ____
Print name: ____

STATEMENT OF WITNESS #1 Under penalty of perjury under the laws of the State of
____________________________ (state where document is signed) on this day of ,
________________________ 20 ____ at ________________________ I stipulate that the following is true and correct: (1) ("Declarer") has been and is personally known to me. (2) I am not (a) related to Declarer by blood, marriage or adoption; (b) entitled to any portion of Declarer's estate upon Declarer's death under any will, or codicil, or any operation of law; (c) declarer's attending physician; (d) an employee of the attending physician or a health facility in which Declarer is a patient; or (e) a person who has a claim against any portion of the estate of Declarer upon Declarer's death. (3). I believe Declarer to be of sound mind and Declarer signed the foregoing Advance Directive willfully and voluntarily.

____ _________________

Witness Signature Print Name

Address____

____________________ ____

STATEMENT OF WITNESS #2 Under penalty of perjury under the laws of the State of
____________________________ (state where document is signed) on this day of ,
________________________ 20 ____ at ________________________ I stipulate that the following is true and correct: (1) ("Declarer") has been and is personally known to me. (2) I am not (a) related to Declarer by blood, marriage or adoption; (b) entitled to any portion of Declarer's estate upon Declarer's death under any will, or codicil, or any operation of law; (c) declarer's attending physician; (d) an employee of the attending physician or a health facility in which Declarer is a patient; or (e) a person who has a claim against any portion of the estate of Declarer upon Declarer's death. (3). I believe Declarer to be of sound mind and Declarer signed the foregoing Advance Directive willfully and voluntarily.

____

Witness Signature Print Name

Address____

____________________ ____

NOTARIZATION (Not required in many states, including Washington) STATE of
________________________ County of ________________________ I certify that I know or have satisfactory evidence that ____ signed this document and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in this document. Dated this _________ of, ________________________ 20 ____
NOTARY PUBLIC in and for the State of ________________________ Residing at:
____ My commission expires on
____