**DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS**

I, (Name)_____, SS#_____, appoint the person named in this document to be my agent to make any healthcare decisions.

This document is a Durable Power of Attorney for Healthcare Decisions. My agent's power shall not end if I become incapacitated or if there is uncertainty that I am dead. This document revokes any prior Durable Power of Attorney for Healthcare Decisions. My agent may not appoint anyone else to make decisions for me. My agent and caregivers are protected from any claims based on the following this Durable Power of Attorney for Healthcare. My agent shall not be responsible for any costs associated with my care. I give my agent full power to make all decisions for me about my healthcare, including the power to direct the withholding or withdrawal of life-prolonging treatment, including artificially supplied nutrition and hydration/ tube feeding. My agent is authorized to

- Consent, refuse, or withdraw consent to any care, procedure, treatment, or service to diagnose, treat, or maintain a physical or mental condition, including artificial nutrition and hydration;
- Permit, refuse, or withdraw permission to participate in federally regulated research related to my condition or disorder;
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home, or other healthcare organization; and, employ or discharge healthcare personnel (any person who is authorized or permitted by the laws of the state to provide healthcare services) as he or she shall deem necessary for my physical, mental, or emotional well-being;
- Request, receive, review, and authorize sending any information regarding my physical or mental health, or my personal affairs, including medical and hospital records; and execute any releases that may be required to obtain such information;
- Move me into or out of any State or institution;
- Take legal actions, if needed;
- Make decisions about autopsy, tissue and organ donations, and disposition of my body in conformity with state law; and
- Become my guardian if one is needed.

In exercising this power, I expect my agent to be guided by my directions as we discussed them prior to this appointment.

Agent's Name

Address

Phone

Email Address

By my signature below, I show that I understand the purpose and the effect of this document.

Signature: _____ Date: _____

Address: _____

Witnesses Signatures

I believe the person who has signed this Durable Power of Attorney for Health Care Decisions to be of sound mind, that she signed or acknowledges this Durable Power of Attorney for Healthcare Decisions in my presence, and that she appears not be acting under pressure, duress, fraud, or undue influence. I am not related to the person making this Durable Power of Attorney for Healthcare Decisions by blood marriage or adoption, nor to the best of my knowledge, am I named in her will. I am not the person appointed in this Durable Power of Attorney for Healthcare Decisions. I am not a health care provider or an employee of a health care provider who is now, or has been in the past, responsible for the care of the person making this Durable Power of Attorney for Healthcare Decisions. I am over the age of 18.

Witness #1 _____ Date:

Name: _____

Signature: _____

Address: _____

Witness #1 _____ Date: _____

Name: _____

Signature: _____

Address: _____