# MEDICAL POWER OF ATTORNEY

I, _____, born _____, of _____, State of _____, am an adult of sound mind. Of my own free will, I appoint _____, my _____, of _____, phone _____, as my health care agent, to make health care decisions for me as this document allows. This power of attorney is not affected by my later disability or incapacity, or by lapse of time.

Before you use this form: states differ on who may serve as an agent, who may witness, whether a notary is needed, whether the agent may act right away, and what an agent may decide about tube feeding. Texas, Kansas, Oregon, Rhode Island and South Carolina expect their own forms, and Texas requires its disclosure statement. New York calls this a Health Care Proxy and Florida a Designation of Health Care Surrogate. Check your state's rules, or use the LawVault builder, which applies them for you.

### 1. ALTERNATE AGENTS

If my agent is not willing, able or reasonably available to act, I appoint _____, phone _____, as my first alternate agent, and _____ as my second alternate agent. An alternate has the same authority as my agent while acting.

### 2. WHEN MY AGENT'S AUTHORITY BEGINS

Initial one: ____ My agent's authority begins once my attending physician determines in writing that I cannot make or communicate my own health care decisions, and stops if I regain that ability. ____ My agent's authority begins when I sign this document, but my own decisions control while I can make them. This document stays in effect until I revoke it.

### 3. MY AGENT'S AUTHORITY

My agent may make any health care decision for me that I could make myself, including to consent to, refuse or withdraw any care, treatment or procedure; to choose and discharge my doctors and other providers; to consent to admission to or discharge from any hospital, nursing home, hospice or other facility; to see and approve the release of my medical records; and to sign any document needed to carry out these decisions.

My agent must follow my written instructions and known wishes, and decide in my best interest when my wishes are not known. My agent may not decide these things: _____

### 4. LIFE-SUSTAINING TREATMENT

Initial one: ____ My agent decides, based on my values and what my doctors advise. ____ If I have an incurable and irreversible condition expected to cause my death soon, or I am permanently unconscious, and there is no reasonable chance I will recover, I do not want life-sustaining treatment. ____ I want life-sustaining treatment for as long as my doctors believe it can keep me alive. Whatever I choose, I want care that keeps me comfortable and relieves pain.

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**5. ARTIFICIAL NUTRITION AND HYDRATION**

INITIAL ONE: ____ MY AGENT MAY CONSENT TO, REFUSE OR STOP ARTIFICIAL NUTRITION AND HYDRATION (FOOD AND FLUIDS THROUGH A TUBE OR A VEIN) FOR ME, IN LINE WITH MY WISHES. I UNDERSTAND THAT STOPPING THEM MAY LEAD TO MY DEATH. ____ I WANT ARTIFICIAL NUTRITION AND HYDRATION GIVEN TO ME UNLESS MY BODY CAN NO LONGER USE THEM OR THEY CAUSE ME HARM.

I want to be offered food and drink by mouth whenever I can safely swallow.

**6. AFTER MY DEATH**

My agent may (initial any): ____ make organ and tissue donations ____ authorize or refuse an autopsy ____ decide how my remains are handled.

**7. SPECIAL INSTRUCTIONS**

_____

_____

**8. HIPAA AUTHORIZATION**

I authorize my health care providers and health plans to disclose my health information, including my complete medical records, to my agent, my alternate agents and _____, so they can help make and carry out decisions about my care. This authorization takes effect now, even before my agent's authority begins, and ends two years after my death. I may revoke it in writing at any time, except where a provider has already acted on it. My treatment will not be conditioned on signing it, and information shared under it may be shared again and lose federal privacy protection. When my agent is deciding for me, my agent is my personal representative under HIPAA.

**9. GUARDIAN, EARLIER DOCUMENTS AND GENERAL TERMS**

If a court must appoint a guardian of my person, I nominate my agent, and then my first alternate agent. This document revokes every earlier health care power of attorney I signed. A living will I signed stays in force, but where it conflicts with this document, this document controls.

I may revoke this document at any time by a signed and dated writing, by destroying it, by telling my agent or a health care provider, or by signing a new health care power of attorney. My agent serves without pay but may be reimbursed for reasonable expenses. A copy has the same effect as the original. This document is not a POLST or do-not-resuscitate order. If part of it is invalid, the rest still applies.

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**SIGNATURES**

**Principal**

Signature: _____ Date: _____

Printed Name: _____

**WITNESSES**

Each witness states: I am an adult. I saw the principal sign, or the principal told me the signature is theirs. The principal appears to be of sound mind and free of pressure. I am not the principal's agent or alternate agent, not related to the principal by blood, marriage or adoption, not entitled to any part of the principal's estate, not financially responsible for the principal's care, and not the principal's doctor or an employee of a provider or facility caring for the principal.

Witness 1: _____ Printed name: _____ Date: _____

Witness 2: _____ Printed name: _____ Date: _____

**NOTARY ACKNOWLEDGMENT (IF YOUR STATE USES ONE)**

State of _____, County of _____. On _____, before me, the undersigned notary public, personally appeared _____, proved to me through satisfactory evidence of identity to be the person who signed this document, and acknowledged signing it voluntarily.

Notary Public: _____ My commission expires: _____ (Seal)

**AGENT'S ACCEPTANCE (REQUIRED IN SOME STATES)**

I accept this appointment. I will act in good faith, follow the principal's written instructions and known wishes, and act in the principal's best interest when those wishes are unknown.

Agent: _____ Date: _____

Alternate agent: _____ Date: _____

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