DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I. DESIGNATION OF HEALTH CARE AGENT

I, _____, residing at:

Street Address: _____

City: _____

State: _____

Zip Code: _____

hereby appoint and designate the following individual as my attorney-in-fact and agent (hereinafter referred to as my "Agent") to make health care decisions on my behalf as authorized in this document:

Agent: _____

Relationship to Principal: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____

II. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By signing this document, I intend to create a Durable Power of Attorney for Health Care. This power of attorney shall not be affected by my subsequent disability or incapacity. This document revokes any prior durable power of attorney for health care or medical proxy executed by me.

III. TRIGGERING EVENT AND DETERMINATION OF CAPACITY

My Agent's authority to make health care decisions under this document shall take effect only if and when I am determined to lack the capacity to make or communicate my own health care decisions. Such determination of incapacity must be made in writing by my attending physician and, if required by applicable state law, a second qualified medical professional, who have personally examined me. My Agent's authority shall cease immediately upon a written determination by my attending physician that I have regained the capacity to make and communicate my own health care decisions.

IV. SCOPE OF AUTHORITY OF AGENT

Subject to any specific limitations stated within this document, I grant my Agent full power and authority to make any and all health care decisions for me to the same extent that I could if I were personally able and competent to do so. This authority includes, but is not limited to, the power to:

1. Consent to, refuse, or withdraw consent for any medical, surgical, dental, or psychological care, treatment, service, diagnostic procedure, or medication.
2. Select, employ, and discharge health care professionals, medical providers, facilities, institutions, and services, including hospitals, nursing homes, assisted living facilities, and hospices.
3. Review, request, receive, and disclose any verbal or written information regarding my physical or mental health, including medical and hospital records.
4. Sign any release, waiver, or consent forms required by medical providers or facilities, including any standard release of liability forms.
5. Make decisions regarding pain management and comfort care, including the administration of pain-relieving medications even if such medications may hasten my death or lead to physical dependency.

V. LIMITATIONS ON AGENT'S AUTHORITY

My Agent shall make health care decisions for me in accordance with this document and my known wishes. If my wishes are unknown, my Agent shall make decisions based on my Agent's assessment of

my best interests.

There are no specific limitations placed on my Agent's authority under this document. My Agent is authorized to make all necessary health care decisions on my behalf in the event of my incapacity, without restriction, subject only to applicable state and federal laws.

VI. PERSONAL BELIEFS AND INSTRUCTIONS

My Agent shall make decisions guided by my personal values. I have not attached any specific religious, cultural, ethical, or spiritual instructions to this document, nor have I included additional specific health care instructions, values, or goals of care. My Agent is fully trusted to exercise their best judgment, keeping my general well-being and comfort as the primary objective.

VII. HIPAA PRIVACY AUTHORIZATION

I intend for my Agent to be treated as my "personal representative" under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. Section 1320d and 45 CFR Parts 160 and 164. My Agent shall have immediate access to my protected health information ("PHI") and medical records. This authority to access my PHI shall take effect immediately upon the execution of this document and shall remain in effect regardless of whether I am currently incapacitated, solely for the purpose of facilitating my Agent's ability to prepare for and make informed medical decisions on my behalf.

VIII. DURABILITY AND SEVERABILITY

This Durable Power of Attorney for Health Care shall survive my subsequent cognitive impairment, physical disability, or mental incapacity. If any provision of this instrument is found to be invalid, illegal, or unenforceable by a court of competent jurisdiction, such invalidity, illegality, or unenforceability shall not affect the remaining provisions, which shall continue in full force and effect.

IX. PRINCIPAL SIGNATURE

I sign my name to this Durable Power of Attorney for Health Care on the date indicated below. I declare that I am of sound mind, under no duress or undue influence, and that I understand the purpose and effect of this document.

PRINCIPAL

Signature: _____

Print Name: _____

Date: _____

Address: _____

WITNESS ATTESTATION

The principal signed this Durable Power of Attorney for Health Care in my presence. I declare under penalty of perjury that the principal appears to be of sound mind and under no duress, fraud, or undue influence. I further declare that I am not the designated health care agent, not a health care provider or an employee of a health care provider currently treating the principal, and not related to the principal by blood, marriage, or adoption.

WITNESS

Signature: _____

Print Name: _____

Date: _____

Address: _____

NOTARY ACKNOWLEDGMENT

State of _____

County of _____

On this _____ day of _____, _____, before me, the undersigned notary public, personally appeared _____, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that they executed the same for the purposes therein contained.

_____

Notary Public Signature

My Commission Expires: _____

[Seal]