DURABLE POWER OF ATTORNEY FOR HEALTHCARE

I. DESIGNATION OF PRINCIPAL AND AGENT

I, _____ (hereinafter "Principal"), born on _____, residing at:

Street Address: _____

City: _____

State: _____

Zip Code: _____

Phone: _____

hereby designate and appoint the following individual as my Agent (also known as Attorney-in-Fact) to make healthcare decisions for me as described in this document: Agent:

_____

Relationship to Principal: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Phone: _____

Email: _____

II. DESIGNATION OF SUCCESSOR AGENTS (OPTIONAL)

If my primary Agent named above is unable or unwilling to serve, or if their authority is terminated, I designate the following individuals, in the order named, as my Successor Agent(s) to serve under this Durable Power of Attorney for Healthcare: First Successor Agent:

_____

Relationship to Principal: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Phone: _____

Email: _____

Second Successor Agent: _____

Relationship to Principal: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Phone: _____

Email: _____

III. EFFECTIVE DATE AND DURATION

This Durable Power of Attorney for Healthcare shall become effective immediately upon my signing of this document. The authority granted to my Agent shall become operative upon a determination by my attending physician that I lack the capacity to make or communicate healthcare decisions. This Durable Power of Attorney for Healthcare shall remain in effect until my death, unless I revoke it sooner.

IV. AUTHORITY OF AGENT

My Agent shall have the full power and authority to make any and all healthcare decisions for me, including but not limited to, those decisions that I could make if I were able to do so, subject to any limitations stated herein. This authority includes, but is not limited to, the power to: 1. **Consent to Medical Treatment:** Give, withhold, or withdraw consent to any diagnostic procedure, medical or surgical treatment, medication, or hospitalization. This includes the power to select or dismiss healthcare providers and facilities.

2. **Access Medical Information:** Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records, and to execute any releases or other documents that may be required to obtain such information. This authorization is intended to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all other applicable federal and state laws.

3. **End-of-Life Decisions:** Make decisions regarding life-sustaining treatment, including the provision or withdrawal of artificial nutrition and hydration, cardiopulmonary resuscitation (CPR), mechanical ventilation, and other life-prolonging measures, in accordance with my known wishes or, if my wishes are unknown, in my best interest.

4. **Organ Donation:** Consent to or refuse organ or tissue donation.

5. **Autopsy and Disposition of Remains:** Authorize an autopsy and make decisions regarding the disposition of my remains, including funeral and burial arrangements, to the extent permitted by law.
6. **Incur Expenses:** Incur reasonable expenses for my healthcare and to access my funds for payment of such expenses.
7. **Sign Documents:** Sign any consents, waivers, releases, or other documents necessary to implement healthcare decisions.

V. LIMITATIONS ON AGENT'S AUTHORITY

My Agent's authority is subject to the following limitations: None specified.

VI. HIPAA AUTHORIZATION

I authorize my Agent, and any Successor Agent, to have access to all my protected health information (PHI) as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations. This authorization permits my Agent to receive, review, and disclose my PHI to healthcare providers, family members, or other persons as my Agent deems necessary to carry out the powers granted in this document. This authorization is effective immediately and shall remain in effect until my death or revocation.

VII. NOMINATION OF GUARDIAN (OPTIONAL)

If a court should determine that it is necessary to appoint a guardian of my person, I nominate my Agent named herein, or my Successor Agent(s) in the order named, to serve as such guardian. None specified.

VIII. REVOCATION

I may revoke this Durable Power of Attorney for Healthcare at any time by a written instrument signed by me, or by my physical destruction of this document, or by an oral statement to my Agent or a healthcare provider, provided I have the capacity to do so. I understand that any such revocation will not be effective as to any third party who has acted in reliance upon this document prior to receiving actual notice of my revocation.

IX. RELIANCE BY THIRD PARTIES

Any physician, hospital, or other healthcare provider, and any other person, may rely on the representations of my Agent as to all matters relating to my healthcare decisions. No person who relies in

good faith upon the authority of my Agent shall incur any liability to me, my estate, or my personal representative for acting in accordance with this Durable Power of Attorney for Healthcare.

X. GOVERNING LAW

This Durable Power of Attorney for Healthcare shall be governed by and construed in accordance with the laws of the state where I reside at the time of execution.

XI. SIGNATURES

IN WITNESS WHEREOF, I have executed this Durable Power of Attorney for Healthcare on the date set forth below.

PRINCIPAL

Signature: _____
Print Name: _____
Date: _____ day of _____, 20_____
Address: _____

XII. AGENT'S ACCEPTANCE

I, _____, hereby accept the designation as Agent and agree to act in accordance with the terms of this Durable Power of Attorney for Healthcare.

AGENT

Signature: _____
Print Name: _____
Date: _____ day of _____, 20_____
Address: _____

XIII. WITNESS ATTESTATION

We, the undersigned witnesses, declare that the Principal, _____, signed this Durable Power of Attorney for Healthcare in our presence, that the Principal appeared to be of sound mind and under no duress or undue influence, and that we are not the Agent or a Successor Agent named

in this document, nor are we related to the Principal by blood, marriage, or adoption, nor are we entitled to any portion of the Principal's estate upon death.

Witness 1

Signature: _____
Print Name: _____
Date: _____ day of _____, 20_____
Address: _____

Witness 2

Signature: _____
Print Name: _____
Date: _____ day of _____, 20_____
Address: _____

XIV. NOTARY ACKNOWLEDGMENT

State of _____
County of _____

On this _____ day of _____, 20_____, before me, a Notary Public in and for said County and State, personally appeared _____ (Principal), known to me or satisfactorily proven to be the person whose name is subscribed to the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal.

Notary Public

Signature: _____
Print Name: _____
My Commission Expires: _____
(Seal)