Durable Health Care Power Of Attorney

I, _____, appoint the following person as **my health care agent** to
(*Print Full Name)*
make health and personal care decisions for me:

Name and Relationship: _____

Address: _____

Phone Numbers: Home _____ Work _____ Cell _____

Email: _____

If the person named above is unable to serve as my health care agent for any reason, I appoint the person named below as **my alternative health care agent**:

Name and Relationship: _____

Address: _____

Phone Numbers: Home _____ Work _____ Cell _____

Email: _____

This document will take effect when and only when I lack the ability to understand, make, or communicate a choice regarding a health or personal care decision, as verified by my attending physician. My health care agent has the following powers (cross out any powers you do not want to give your health care agent):

1. To authorize, withhold, or withdraw medical care and surgical procedures.
2. To authorize, withhold, or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries, or veins.
3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.
4. To hire and fire medical, social service, and other support personnel responsible for my care.
5. To take any legal action necessary to do what I have directed.
6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.
7. To authorize or refuse donation of organs or tissue.

Having carefully read this document, I have signed it on _____, revoking all previous health care powers of attorney.
(*Today's Date)*

Signature: _____DOB: _____

Witness: _____

Witness: _____