

Disclosure Statement for Medical Power of Attorney

This is an important legal document. Before signing this document, you should know the following important facts. Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because “health care” means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition, your agent has the power to consent or withdraw consent to medical treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery or abortion. A physician must comply with your agent’s instructions or allow you to be transferred to another physician.

Your agent’s authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care, as you would have.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer’s assistance to complete this document, but if there is anything in this document you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disability of minority removed. If you appoint your health or residential care provider (i.e.: your physician or an employee of a home health agency, hospital, nursing home or residential care home; other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself, the people and institutions that have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing by your execution of subsequent Medical Power of Attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

Medical Power of Attorney

Designation of Health Care Agent

I, _____, appoint:

Name	Address	Date
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as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This Medical Power of Attorney takes effect if I become unable to make my own health care decisions and my physician certifies this fact in writing.

Limitations on the decision-making authority of my agent are as follow:

Designation of an Alternate Agent:

You are not required to designate an alternative agent, but you may do so. An alternative agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, law automatically revokes the designation if your marriage is dissolved.

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s) to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent:

Name	Address	Phone
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Second Alternate Agent:

Name	Address	Phone
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The original of this document is kept at _____

The following individuals or institutions have signed copies:

Name	Address
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Name	Address
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Duration:

I understand that this Medical Power of Attorney exists indefinitely from the date I execute this document, unless I establish a shorter time or revoke this document. If I am unable to make health care decisions for myself when this Medical Power of Attorney expires, I have granted that my agent continues to exist until the time I become able to make health care decisions for myself.

If applicable, this Medical Power of Attorney ends on the following date: _____

Prior Designations Revoked:

I revoke any prior Medical Power of Attorney, which I may have executed.

Acknowledgment of Disclosure Statement:

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in this disclosure statement.

You must sign and date this Medical Power of Attorney.

This Medical Power of Attorney is not valid unless it is signed in the presence of two competent adult witnesses.

I sign my name to this Medical Power of Attorney on _____ day of _____, 20____ at

City and State

Signature of Declarant

Print Name

Statement of Witnesses:

I am not the person appointed as agent by this document. I am not related to the declarant by blood or marriage. I would not be entitled to any portion of the declarant’s estate upon the declarant’s death. I am not the attending physician of the declarant or an employee of the attending physician. I have no claim against any portion of the declarant’s estate upon the declarant’s death. Furthermore, if I am an employee of a health care facility in which the declarant is a patient, I am not involved in providing direct care to the declarant and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

First Witness Signature Print Name Address Date

Second Witness Signature Print Name Address Date