MEDICAL POWER OF ATTORNEY

WITH ADVANCE DIRECTIVE

PART I

POWER OF ATTORNEY FOR HEALTH CARE

1. I, _____, presently residing at _____, _____, _____ _____ (the "Principal"), do hereby nominate, constitute, and appoint _____, presently residing at _____, _____, _____ _____, as my true and lawful attorney-in-fact ("agent"), to act for me and in my name, place, and stead, and for my use and benefit for health care purposes.

Agent's phone: _____

Agent's email: _____

If the original agent or a substitute agent is unable to act, then, in such case, one (1) of the following documents shall be attached to this Power of Attorney for Health Care: a resignation or declination to serve signed by the previous agent; a written and signed statement from a licensed physician that the previous named agent is physically or mentally incapable of serving; a certified court order as to the incapacity or inability of the previous named agent to serve; or a certified death certificate of the previous named agent. Third parties who deal with the substitute agent shall be entitled to rely on the original power of attorney instrument, or a photocopy thereof, with any such document attached.

In the event of my incapacity, my agent will have full power and authority to make health care decisions for me, including, but not limited to, the power and authority to do the following:

2. This Health Care Power of Attorney shall become effective only upon the incapacity of the Principal, as determined and evidenced by a written certificate or statement of the Principal's treating physician, stating that the Principal lacks substantial capacity to make informed health care decisions on the Principal's own behalf. The powers granted herein to the agent shall continue notwithstanding such incapacity and shall cease when the Principal is deemed to have regained capacity as determined and evidenced by the written certificate or statement of the attending physician.

When in the process of determining my incapacity (as it relates to this instrument, or any trust agreement or durable general power of attorney executed by me), all individually identifiable health information and medical records may be released under the HIPAA Release Authority granted under Section 3, to the person nominated as my agent, including any written opinion relating to my incapacity that the person so nominated may have requested. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164, and applies even if that person is not yet serving as my agent.

3. I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care professional, any insurance company, the Medical Information Bureau Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

The authority given my agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

4. My agent shall exercise the powers granted under this Power of Attorney in accordance with any instructions set forth in Part II below and my wishes to the extent otherwise known to my agent. To the extent my wishes are unknown, my agent shall exercise the powers granted under this power of attorney in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

5. I hereby ratify and confirm all that my agent shall lawfully do or cause to be done by virtue of this Power of Attorney and hold harmless any person or entity who suffers loss or liability from reliance upon such lawful exercise of this Power of Attorney.

6. If a conservator of my person needs to be appointed for me by a court, I nominate my agent designated in this document. If my agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

7. Only one (1) original of this instrument has been executed. My agent is authorized to make photocopies of this instrument and any attached documents (such as statements of incapacity) as frequently and in such quantities as my agent deems appropriate. Each photocopy shall have the same force and effect as the original, and all parties dealing with my agent are authorized to rely fully on any such photocopy showing the principal's signature thereon.

PART II

ADVANCE HEALTH CARE DIRECTIVE

1. End-of-Life Decisions. I request that my health care providers and others involved in my care withhold or withdraw all treatments other than those needed to keep me comfortable, and that I am allowed to die as gently as possible:

PART III

GENERAL PROVISIONS

1. I revoke all prior powers of attorney for health care (but not durable general powers of attorney for asset management), living wills, and directives to physicians that I may have executed. I retain the right to revoke or amend any portion of this instrument and to substitute other agents in place of the agents appointed in Part I, Section 1 of this instrument.

2. If any of the provisions of this instrument is invalid for any reason, such invalidity shall not affect any of the other provisions of this instrument, and all invalid provisions shall be fully disregarded.

3. All questions pertaining to validity, interpretation, and administration of this instrument shall be determined in accordance with the laws of the state of residence of the Principal.

4. This instrument may be revoked or terminated at any time by the Principal. This instrument will exist for an indefinite period of time unless revoked or terminated.

IN WITNESS WHEREOF, I have hereunto set my hand on _____.

_____

(signature)

_____

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of _____)

) ss

County of _____)

On _____ before me, _____, personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of _____ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

GENERAL INFORMATION

This document gives the person you designate as your agent (the agent) the power to make health care decisions for you. It also gives you the opportunity to set forth specific instructions regarding your health care. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to the instructions and any other limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent **(1)** authorizes anything that is illegal, **(2)** acts contrary to your known desires, or **(3)** where your desires are not known, does anything that is clearly contrary to your best interests.

This power will exist for an indefinite period of time unless you limit its duration in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to **(1)** authorize an autopsy, **(2)** donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and **(3)** direct the disposition of your remains.