

Medical Power of Attorney

An appointment of a health care agent for an adult who lives in any US state, with a HIPAA authorization and the principal's wishes. Some states call it a health care proxy or health care power of attorney. Template v1.0.

Principal, the person making this document: _____

Date of birth: _____

Address:

State where I live: _____

1. My health care agent

I appoint as my health care agent:

2. Alternate agent

If my agent is not willing, able or reasonably available to decide, or is my spouse and our marriage ends by divorce

3. When my agent may act

My agent may make health care decisions for me only when my attending physician, or another health care professional the law of my state allows, determines that I am unable to make or communicate my own health care decisions and records that finding in my medical record. If I regain that ability, the decisions are mine again. My agent may receive my health information under section 6 at any time.

4. My agent's authority

My agent may make any health care decision for me that I could make myself, except a decision the law of my state does not allow an agent to make. This includes the power to:

- (a) Consent to, refuse or withdraw any care, treatment, test, medicine or procedure, including life-sustaining treatment such as a breathing machine, resuscitation, and artificial nutrition and hydration by tube.

- (b) Choose, hire and dismiss doctors, other health care providers, hospitals, nursing homes and hospice programs, and admit me to or discharge me from any of them.
- (c) See, receive and allow others to see my medical records and other health information.
- (d) Sign consents, waivers, releases and other papers needed to carry out these decisions.

My agent will decide as I would want, following my instructions in this document and my wishes as my agent knows them. Where my wishes are not known, my agent will decide in my best interest, taking my values into account.

5. My wishes about end-of-life care

My wishes about life-sustaining treatment:

6. HIPAA authorization

I authorize every health care provider, health plan and other entity covered by the federal HIPAA privacy rules at 45 CFR parts 160 and 164 to disclose all of my individually identifiable health information to my agent and my alternate agent, including information about mental health, alcohol or drug treatment and other sensitive conditions as far as the law allows. The purpose is to let them make informed decisions and act for me.

This authorization is effective now, whether or not I can make my own decisions, and ends two years after my death unless I revoke it earlier. I may revoke it at any time by writing to the provider or plan that holds my information, except to the extent they have already acted on it. My treatment, payment, enrollment or eligibility for benefits does not depend on my signing it. Information disclosed under it may be disclosed again by the person who receives it and may then no longer be protected by HIPAA.

7. Organ and tissue donation

My wishes about donating organs and tissue after my death: _____

My agent may carry out these wishes as far as the law allows.

8. Other instructions

Other instructions or limits:

9. Earlier documents and copies

This document revokes any earlier health care power of attorney, health care proxy or appointment of a health care agent I have made. A living will or other written instructions I signed before this document stay in effect, but where they conflict with this document, this document controls. A copy of this signed document has the same effect as the original. If a court must appoint a guardian of my person, I nominate my agent.

Signature of the principal

I understand this document and sign it willingly on the date below.

Principal

Signature

Name

Date

Statement of witnesses

Each of us declares that the principal signed this document, or acknowledged signing it, in our presence, is personally known to us or showed us proof of identity, and appears to be of sound mind and free of duress, fraud or undue influence. Each of us is an adult, is not the agent or alternate agent named in this document, and is not the principal's health care provider or an employee of that provider.

First witness

Signature

Name

Date

Address

Second witness

Signature

Name

Date

Address

Notary acknowledgment

Notary acknowledgment

For the notary public only. The notary completes the certificate of acknowledgment that the law of the place of signing requires, in this space or on a certificate attached to this page.