# Medical Power of Attorney



## MEDICAL POWER OF ATTORNEY

### 1. INTRODUCTION

1.1. Principal. I, [PRINCIPAL NAME], born [DOB], residing at [ADDRESS], [CITY], [STATE] [ZIP], hereby designate an Agent to make health care decisions on my behalf as provided in this Medical Power of Attorney.

1.2. Purpose. This document is intended to grant my Agent authority to make all medical and health care decisions for me, including consent or refusal of medical treatment, subject to any limitations stated below.

### 2. DESIGNATION OF AGENT

2.1. Primary Agent. I appoint [AGENT NAME], residing at [AGENT ADDRESS], [CITY], [STATE] [ZIP], telephone [AGENT PHONE], as my Agent to make health care decisions for me.

2.2. Alternate Agent. If the person named above is unavailable, unwilling, or unable to serve, I appoint [ALTERNATE AGENT NAME], residing at [ALTERNATE AGENT ADDRESS], [CITY], [STATE] [ZIP], telephone [ALTERNATE AGENT PHONE], as my alternate Agent.

### 3. AGENT'S AUTHORITY

3.1. General Authority. Subject to any limitations in this document, my Agent is authorized to make all health care decisions for me to the same extent and with the same effect as I could do if I were competent, including but not limited to:

a. consenting, refusing, or withdrawing consent to any medical care, treatment, surgical procedure, diagnostic procedure, medication, and life-sustaining treatment;

b. selecting or discharging health care providers and institutions;

c. arranging for medical consultation, treatment, palliative care, hospice, and nursing care;

d. accessing medical records and communicating with health care providers;

e. making decisions about organ or tissue donation, autopsy, and disposition of remains as set forth in Section 7.

3.2. Life-Sustaining Treatment. Unless I have provided specific instructions in Section 7 or elsewhere in this document, my Agent has the authority to make decisions regarding the provision, withholding, or withdrawal of life-sustaining treatments, including mechanical ventilation, cardiopulmonary resuscitation (CPR), artificial nutrition and hydration, and other forms of life support.

### 4. EFFECTIVE DATE AND DURABILITY

4.1. Effective Date. This Medical Power of Attorney shall become effective [SELECT: IMMEDIATELY / UPON MY INCAPACITY]. (If you choose "UPON MY INCAPACITY," the incapacity of the Principal must be determined as provided in Section 4.2.)

4.2. Determination of Incapacity. Unless otherwise required by applicable state law, my incapacity shall be determined by my attending physician in consultation with any other treating physician(s) and documented in my medical record. If two physicians cannot agree, the determination shall be made in accordance with applicable law.

4.3. Durability. This Medical Power of Attorney shall not be affected by my subsequent disability or incapacity and shall remain in effect until revoked in accordance with Section 9 or until my death.

### 5. HIPAA AUTHORIZATION

5.1. Authorization. I authorize my Agent to request, receive, and review my protected health information

(PHI), including medical records and other communications, and to sign any releases or other documents necessary to obtain such information, to the fullest extent permitted under the Health Insurance Portability and Accountability Act (HIPAA) and any other applicable privacy laws.
5.2. Duration. This authorization is valid as long as this Medical Power of Attorney is in effect and may be revoked in writing pursuant to Section 9.

## 6. LIMITATIONS ON AGENT'S AUTHORITY

6.1. Limitations. My Agent shall NOT have authority to make the following decisions (check any that apply and specify):
[ ] I DO NOT authorize my Agent to refuse or withdraw life-sustaining treatment under any circumstances.
[ ] I DO NOT authorize my Agent to admit me to or discharge me from a mental health institution.
[ ] Other limitations: [SPECIFY LIMITATIONS OR INSTRUCTIONS].
6.2. Binding Instructions. To the extent that this document contains specific instructions regarding health care treatment, those instructions are intended to be binding on my Agent.

## 7. PERSONAL HEALTH CARE INSTRUCTIONS (OPTIONAL)

7.1. Specific Directions. The following wishes and instructions represent my preferences and shall guide my Agent:
a. Pain management and palliative care preferences: [SPECIFY PREFERENCES].
b. Artificial nutrition and hydration: [CONSENT / REFUSE / CONDITIONAL TERMS].
c. Cardiopulmonary resuscitation (CPR): [CONSENT / REFUSE].
d. Organ and tissue donation: [DONATE / DO NOT DONATE] as follows: [SPECIFY].
e. Other specific directions: [SPECIFY].

## 8. NOMINATION OF GUARDIAN OR CONSERVATOR

8.1. Nomination. In the event that a court decides to appoint a guardian or conservator for my person or estate, I nominate [GUARDIAN NOMINEE NAME], residing at [GUARDIAN NOMINEE ADDRESS], [CITY], [STATE] [ZIP], to serve in that role. If that person is unavailable, I nominate [ALTERNATE GUARDIAN NAME].

## 9. REVOCATION

9.1. Revocation by Principal. I may revoke this Medical Power of Attorney at any time by a written and signed statement delivered to my Agent and to my attending health care provider. Oral revocation is effective to the extent permitted by law.
9.2. Revocation by Subsequent Instrument. This Medical Power of Attorney may also be revoked or amended by a subsequent durable power of attorney for health care or other written instrument signed by me.

## 10. AGENT ACCEPTANCE; DUTIES AND LIMITS

10.1. Acceptance. By signing below, my Agent and any alternate Agent accept their appointment and agree to act in accordance with this document and applicable law.
10.2. Duties. My Agent shall act in my best interest, in accordance with any known wishes, religious beliefs, and other instructions I have provided, and when my wishes are unknown, in consultation with my health care providers and family.
10.3. No Obligation to Act. My Agent is not required to undertake actions that would violate applicable law or be contrary to accepted medical practice.
10.4. Reimbursement and Compensation. My Agent shall serve without compensation except as provided by separate written agreement or by applicable law. My Agent is entitled to reasonable reimbursement for out-of-pocket expenses incurred while acting under this authority.

## 11. LIABILITY

11.1. Standard of Care. My Agent shall not be liable for acts or omissions made in good faith reliance upon this document, upon the advice of counsel, or upon the advice of health care providers. This provision is subject to applicable state law and does not protect against willful misconduct or gross negligence.

## 12. COPIES; PRESUMPTION OF VALIDITY

12.1. Copies. A copy of this Medical Power of Attorney has the same effect as the original.

12.2. Validity. Any health care provider presented with a copy of this document may rely on its validity and on the authority of the Agent named herein, unless notified otherwise in writing.

## 13. GOVERNING LAW

13.1. Governing Law. This Medical Power of Attorney shall be governed by and construed in accordance with the laws of the State of [STATE], without regard to conflict of laws principles.

## 14. SEVERABILITY

14.1. Severability. If any provision of this document is held invalid or unenforceable, the remaining provisions shall remain in full force and effect.

## 15. SIGNATURES

15.1. Principal's Signature. I sign my name to this Medical Power of Attorney on this [DATE] day of [MONTH], [YEAR], and I declare that I understand the contents of this document and that I am emotionally and mentally competent to execute it.

Signature of Principal: _____ Date: _____
[PRINCIPAL NAME]

15.2. Agent's Acceptance. I, [AGENT NAME], accept the appointment as Agent under this Medical Power of Attorney and agree to exercise the powers granted to me in accordance with the terms of this document and applicable law.

Signature of Agent: _____ Date: _____
[AGENT NAME]

15.3. Alternate Agent's Acceptance (Optional). I, [ALTERNATE AGENT NAME], accept the appointment as alternate Agent under this Medical Power of Attorney.

Signature of Alternate Agent: _____ Date: _____
[ALTERNATE AGENT NAME]

## 16. WITNESSES

16.1. Witness Requirement. (Many states require two witnesses who are not named as Agents, not beneficiaries of the Principal's estate, and not health care providers.) The undersigned witnesses declare that the Principal appeared to be of sound mind and under no duress, fraud, or undue influence, signed this document in their presence, and that the witnesses signed in the presence of the Principal and each other.

Witness 1:
Name: _____ Address: _____
City/State/Zip: _____ Signature: _____ Date: _____

Witness 2:
Name: _____ Address: _____
City/State/Zip: _____ Signature: _____ Date: _____

[If your state requires notarization, complete the acknowledgment below.]

## 17. NOTARY ACKNOWLEDGMENT

STATE OF _____
COUNTY OF _____

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared [PRINCIPAL NAME], personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument, and acknowledged to me that he/she executed the same for the purposes herein contained.

WITNESS my hand and official seal.

Notary Public Signature: _____
Printed Name: _____
My Commission Expires: _____
(Seal)

## 18. ADDITIONAL PROVISIONS (OPTIONAL)

18.1. Additional Terms. Include any additional provisions, preferences, or instructions in the space below. Attach additional pages if necessary and initial each additional page.

[ADDITIONAL INSTRUCTIONS OR PROVISIONS]

## 19. NOTICE

19.1. Legal Advice. This template is provided as a general form. The laws governing advance directives and powers of attorney vary by state. It is recommended that the Principal review this document with an attorney or legal advisor and ensure compliance with the laws of [STATE].

## END OF MEDICAL POWER OF ATTORNEY