DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, of _____, being of sound mind, voluntarily create this Durable Power of Attorney for Health Care.

PRIOR DESIGNATIONS

I revoke any prior Durable Power of Attorney for Health Care.

APPOINTMENT OF HEALTH CARE AGENT

In the event that I have been determined to be incapable of providing informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my agent for health care decisions:

_____

_____

Telephone: _____

Relationship: _____

AGENT'S AUTHORITY

My agent is authorized to act for me in all matters relating to my health care. My agent's powers include, but are not limited to:

- Full power to consent, refuse consent, or withdraw consent to all medical, surgical, hospital and related health care treatments and procedures on my behalf, according to my wishes as stated in this document, or as stated in a separate Living Will, Health Care Directive, or other similar type document, or as expressed to my agent by me;

- Full power to make decisions on whether to provide, withhold, or withdraw artificial nutrition and hydration on my behalf, according to my wishes as stated in this document, or as stated in a separate Living Will, Health Care Directive, or other similar type document, or as expressed to my agent by me;

- Full power to review and receive any information regarding my physical or mental health, including medical and hospital records, in accordance with the *Health Insurance Portability and Accountability Act of 1996,* 42 USC 1320d ("HIPAA"), and the*American Recovery and Reinvestment Act of 2009* ("ARRA");

- Full power to sign any releases in order to obtain this information;

- Full power to sign any documents required to request, withdraw, or refuse treatment or to be released or transferred to another medical facility.

My agent does not have authority to act for me for any other purpose unrelated to my health care. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions have the same effect on my heirs, devisees and personal representatives as if I were competent and acting for myself.

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE

The designation of my health care agent will become effective on my inability to make or communicate health care decisions as determined by my attending physician and will remain in effect until my death, or until I regain competence and revoke it.

AGENT'S OBLIGATIONS

My agent will make health care decisions for me in accordance with this document, and in accordance with any instructions I give in a Living Will, Health Care Directive or other such document (either included in this document or as a separate document), and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent will make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent will consider my personal values to the extent known to my agent.

NOMINATION OF CONSERVATOR OR GUARDIAN

If a conservator or guardian of my person needs to be appointed for me by a court, I nominate _____, the agent designated in this form. My nominated conservator or guardian is not required to post bond or security.

EFFECT OF COPY

A copy of this Durable Power of Attorney for Health Care has the same effect as the original.

SEVERABILITY

If any part or parts of this Durable Power of Attorney for Health Care is found to be invalid or illegal under applicable law by a court of competent jurisdiction, the invalidity or illegality of such part or parts shall not in any way affect the remaining parts, and this document shall be construed as though the invalid or illegal part or parts had never been included herein. But if the intent of this Durable Power of Attorney for Health Care would be defeated by such construction, then it shall not be so construed.

SIGNATURE

This Durable Power of Attorney for Health Care is made after careful reflection, while I am of sound

mind. I am fully informed as to all contents of this document and understand the full import of this grant of powers to my agent. I fully understand that by signing this document, I will permit my agent to make health care decisions for me. I understand that my signature on this document gives my agent authority to provide, withhold, or withdraw consent to health care treatments or procedures on my behalf; to apply for public benefits to defray the cost of my health care; and to authorize my admission to or transfer from a health care facility. I further affirm that I am not signing this document as a condition of treatment or admission to a health care facility.

Signature: _____

Name: _____

Date: _____

Place: _____, _____

RECORD OF COPIES

Record of people and institutions to whom I have given a signed copy of this document:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

INSTRUCTIONS FOR HEALTH CARE

If I, _____, become incapacitated and am unable to direct my health care providers as to my own health care, I direct that this statement be read as a true reflection of my health care wishes.

DEFINITIONS

For the purposes of this document, the following definitions apply:

1. **"Artificially administered food and water"** (or artificial nutrition and hydration) means the provision of nutrients or fluids by a tube inserted in vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

2. **"Attending physician"** means the physician licensed by the state board of medicine, selected by or assigned to the patient, and who has primary responsibility for the treatment and care of the patient.

3. **"Comfort care"** means treatment, including prescription medication, provided to the patient for the sole purpose of alleviating pain. Artificially administered food and water is not included.

4. **"Health care provider"** or "provider" means any person licensed, certified, or otherwise authorized by law to administer health care in the ordinary course of business or practice of a profession.

5. **"Irreversible (Permanent) Coma"** means a profound state of unconsciousness caused by disease, injury, poison, or other means and for which it has been determined that there exists no reasonable expectation of regaining consciousness.

6. **"Life-prolonging procedure"** (or **"life-sustaining procedure"**) means any medical procedure, treatment, or intervention which sustains, restores, or supplants a spontaneous vital function. In this document the term does not include sustenance and hydration administration, or the provision of medication or the performance of medical procedure, when such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.

7. **"Persistent vegetative state"** means a permanent and irreversible condition in which there is:
    a. The absence of voluntary action or cognitive behavior of any kind.
    b. An inability to communicate or interact purposefully with the environment.

8. **"Terminal condition"** means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

MEDICAL DIRECTIONS AND END-OF-LIFE DECISIONS

I direct that my health care providers and others involved in my care, provide, withhold, or withdraw treatment in accordance with my directions below: (Review and initial where indicated)

1. If I have an incurable and irreversible (terminal) condition that will result in my death within a relatively short time, I direct that:
    - o I be removed from any artificial life support or any additional life-prolonging treatment. _____ my initials
    - o I not be artificially administered food and water, realizing this may hasten my death. _____ my initials
    - o I not be provided any comfort care, and relief from pain, including any pain reduction medication, if the effect would be to prolong my life. _____ my initials

2. If I am diagnosed as being in an irreversible coma and, to a reasonable degree of medical certainty, I will not regain consciousness, I direct that
    - o I be removed from any artificial life support or any additional life-prolonging treatment. _____ my initials
    - o I not be artificially administered food and water, realizing this may hasten my death. _____ my initials
    - o I not be provided any comfort care, and relief from pain, including any pain reduction medication, if the effect would be to prolong my life. _____ my initials

3. If I am diagnosed as being in a persistent vegetative state and, to a reasonable degree of medical certainty, I will not regain consciousness, I direct that:
    - o I be removed from any artificial life support or any additional life-prolonging treatment. _____ my initials
    - o I not be artificially administered food and water, realizing this may hasten my death. _____ my initials

o I not be provided any comfort care, and relief from pain, including any pain reduction medication, if the effect would be to prolong my life. _____ my initials

ADDITIONAL INSTRUCTIONS

I have no additional instructions.

I understand that I may change the above-listed directives at any time by revoking this declaration and writing a new one.

EFFECT OF COPY

A copy of this Instructions for Health Care has the same effect as the original.

SEVERABILITY

If any part or parts of this Instructions for Health Care is found to be invalid or illegal under applicable law by a court of competent jurisdiction, the invalidity or illegality of such part or parts shall not in any way affect the remaining parts, and this document shall be construed as though the invalid or illegal part or parts had never been included herein. But if the intent of this Instructions for Health Care would be defeated by such construction, then it shall not be so construed.

SIGNATURE

This document is made upon careful reflection. Options that I have considered and rejected are not printed above. I confirm that the health care directions contained herein were made after careful consideration and in full awareness of other options that may have been available to me. I declare that I am an adult in the State of California, that I understand the full import of this declaration, and that I am emotionally and mentally competent to give these directions.

Signed at _____, in the State of California, this _____ day of _____, _____.

Signature: _____

Name: _____

Address: _____

_____, _____

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 CALIFORNIA

COUNTY OF _____

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

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

WITNESS my hand and official seal.

_____
Notary Public

_____
(print name)

RECORD OF COPIES

Record of people and institutions to whom I have given a signed copy of this document:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____