

Medical Power of Attorney Effective Upon Execution

I, _____, a resident of _____;

Social Security Number _____ designate _____,
presently residing at _____,
telephone number _____ as my agent to make any and all
health care decisions for me, except to the extent I state otherwise in this
document. For the purposes of this document, "health care decision" means
consent, refusal of consent, or withdrawal of consent to any care, treatment,
service, or procedure to maintain, diagnose, or treat an individual's physical or
mental condition. This medical power of attorney takes effect if I become unable
to make my own health care decisions and this fact is certified in writing by my
physician.

Limitations: _____

Inspection and Disclosure of Information Relating to My Physical or Mental Health: Subject to any limitations in this document, my agent has the power and authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records;
2. Execute on my behalf any releases or other documents that may be required in order to obtain this information;
3. Consent to the disclosure of this information.

Additional Powers: Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

1. Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice";
2. Any necessary waiver or release from liability required by a hospital or physician.

Duration: This power of attorney exists indefinitely from its date of execution, unless I establish herein a shorter time or revoke the power of attorney.

[If applicable: This power of attorney expires on _____. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent shall continue to exist until such time as I become able to make health care decisions for myself.]

Alternative Agent: In the event that my designated agent becomes unable, unwilling, or ineligible to serve, I hereby designate _____,

presently residing at _____,
telephone number _____ as my as my first alternate agent, and
_____, presently residing at _____
_____, telephone number _____
as my as my second alternate agent.

Prior Designations Revoked: I revoke any prior Medical Power of Attorney.

Location of Documents:

The original copy of this Medical Power of Attorney is located at [Location].

Signed copies of this Medical Power of Attorney have been filed with the
following individuals and institutions: _____
_____.

I sign my name to this Medical Power of attorney on the date of _____,
at _____.

NAME

Statement of Witnesses

I hereby declare under penalty of perjury that the person who signed or
acknowledged this document is personally known to me (or proved to me on the
basis of convincing evidence) to be the principal, that the principal signed or
acknowledged this durable medical power of attorney in my presence, that the
principal appears to be of sound mind and under no duress, fraud, or undue
influence. I am not the person appointed an agent by this document. I am not
related to the principal by blood, marriage, or adoption. I would not be entitled to
any portion of the principal's estate on the principal's death. I am not the
attending physician of the principal or an employee of the attending physician. I
have no claim against any portion of the principal's estate on the principal's
death. Furthermore, if I am an employee of a health care facility in which the
principal is a patient, I am not involved in providing direct patient care to the
principal 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.

Witness

Witness

Subscribed and sworn to before me on [DATE].

Notary Public, [COUNTY, STATE]
My commission expires _____.