

RECORDING REQUESTED BY AND MAIL TO:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## POWER OF ATTORNEY FOR HEALTH CARE

(Durable Power of Attorney)

1. **Creation of Power of Attorney for Health Care.** By this document I, *(fill in full legal name)*

\_\_\_\_\_, a resident of \_\_\_\_\_ County, California, intend to create *(fill in county of domicile)*

a power of attorney for health care. A power of attorney enables the person designated below to make health care decisions for me as permitted in California Probate Code sections 4600-4805, Health Care Decisions Law operative July 1, 2000. This power of attorney shall remain in force for an indefinite period of time and shall not be affected by my subsequent incapacity. I intend that my health care agent(s) be my personal representative within the meaning of and have all of the same rights as I would have under the Health Insurance Portability and Accountability Act of 1996, together with further amendments, 42 USC 1320d and 45 CFR 160-164.

2. **Designation of Health Care Agent.** I do hereby designate and appoint the following persons as agents, each of them severally and not jointly, my attorneys in fact, and each of them shall be referred to in this power of attorney as "my attorney in fact." Each of these persons, acting alone, shall have full power and authority to act on my behalf under the terms of this power of attorney:

<p>_____ <i>(Enter name of First Alternate Agent)</i></p> <p>_____ <i>(Enter street address)</i></p> <p>_____ <i>(Enter City, State and Zip Code)      (Phone Number)</i></p>
<p>_____ <i>(Enter name of Second Alternate Agent)</i></p> <p>_____ <i>(Enter street address)</i></p> <p>_____ <i>(Enter City, State and Zip Code)      (Phone Number)</i></p>
<p>_____ <i>(Enter name of Third Alternate Agent)</i></p> <p>_____ <i>(Enter street address)</i></p> <p>_____ <i>(Enter City, State and Zip Code)      (Phone Number)</i></p>

<hr/> <p style="text-align: center;"><i>(Enter name of Fourth Alternate Agent)</i></p> <hr/> <p style="text-align: center;"><i>(Enter street address)</i></p> <hr/> <p style="text-align: center;"><i>(Enter City, State and Zip Code)      (Phone Number)</i></p>
<hr/> <p style="text-align: center;"><i>(Enter name of Fifth Alternate Agent)</i></p> <hr/> <p style="text-align: center;"><i>(Enter street address)</i></p> <hr/> <p style="text-align: center;"><i>(Enter City, State and Zip Code)      (Phone Number)</i></p>

*(Should the addresses of any of the above-named Agents change, the new address can be listed on the last page of this document. Do not scratch out and change addresses)*

**2.(B) Negative designation.**

I have specifically, intentionally and willingly appointed the above persons to be my agent(s), my sole agent(s), my only spokesperson(s), who shall consult with my health care providers and ensure that my health care wishes are honored. Under no circumstances shall my health care provider consider any input from the below named persons, and under no circumstances shall they participate in any health care decision making on my behalf. *(enter names below)*


**3. General Statement of Authority Granted.**

A. If I become incapable of giving an informed consent to any health care decision, I hereby grant to my agent full power and authority to consent, refuse consent, or withdraw consent to any type of health care procedure (including any procedure to maintain, diagnose, or treat any physical or mental condition), or to make any other health care decision, to the same extent that I could if I were competent to do so, subject to the terms of this instrument. My agent shall exercise this power and authority in accordance with my expressed desires, known to my agent, whether contained in this document or not. Before acting, my agent shall attempt to communicate with me regarding my desires unless such attempt would be futile. If my desires are unknown, then my agent should decide for me, having my best interests in mind. My agent is further authorized:

To authorize, or refuse to authorize, any health care decision, or medical treatment, if I shall be physically or mentally incapacitated or otherwise unable to make such authorization for myself, including but not limited to authorization for emergency care, hospitalization, surgery, therapy, and/or any other kind of treatment or procedure that, in my agent's sole discretion, my agent thinks necessary for my benefit and well being.

To consult with and advise any physicians, nurses, therapists, dentists, or any other medical and/or health care institutions on my behalf, as such consultations relate to my health and welfare. All such personnel and institutions are specifically requested to abide by any and all decisions and instructions of my agent and to release to my agent any and all information that my agent may request concerning my health and well being.

To receive into my agent's sole possession any and all items of personal property and effects that may be recovered from or about my person by any hospital, police agency, or any other person at the time of my illness, disability, or death, this to specifically include my remains, if applicable.

B. "Health care decisions" means consent, refusal of consent, or withdrawal of consent for any care, treatment, service, or procedure to affect my physical or mental condition, as well as consent to release of medical information.

C. I trust each agent I have appointed, and each knows and understands my desires, and in whose judgment I have absolute faith, to exercise the agent's discretion in a manner that would be satisfactory to me if I had the capacity to give or refuse to give consent.

D. Before acting, my agent shall attempt to communicate with me regarding my desires unless such attempt would be futile. If I am unreachable by such communication, and my desires regarding a particular health care decision are unknown, my agent should make the health care decision guided by the following: any preferences that I have previously expressed, preferences stated herein, and information received from the attending physician(s) concerning my prognosis, all the while having my best interests in mind.

E. If a Declaration under the Natural Death Act, as set forth in the California Health and Safety Code, is signed by me, whether it is signed before, in conjunction with, or after this Durable Power of Attorney for Health Care, it is my intention that the language in the Natural Death Act should in no way limit the powers given to my agent in this document. If I have signed a Declaration, it was with the hope that the cumulative effect of both documents would help implement my intentions.

4. **Statement of Desires, Special Provisions, and Limitations.** In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below.

(a) Statement of Desires Concerning Life-Prolonging Care, Treatment, Services, and Procedures:  
(Initial One)

**Artificial Life Support Desired: (initial choice)**

\_\_\_\_\_ I express the desire that my life be prolonged to the greatest possible extent without regard for my physical or mental condition, chance of recovery, likelihood of suffering, or expense and authorize my agent to consent to whatever medical procedures are necessary to accomplish this end. I trust my agent, who knows my desires well, and in whose judgment I have absolute faith to exercise the agent's discretion in a manner that would be satisfactory to me.

*see next---*

**Artificial Life Support Not Desired - the "Living Will" type provision:**

\_\_\_\_\_ If I have an incurable or irreversible physical or mental condition, even if I am not in a persistent vegetative state or some other form of permanent unconsciousness, I want care and treatment that will enable me to take part in activities of daily living, to eat and drink and to communicate meaningfully with others. I want to live my life with dignity and for my loved ones to have pleasant memories of my final days. Thus, I wish to be allowed to die without prolonging my death with medical treatment including artificial nutrition and hydration that will not benefit me.

I wish to make my own decisions as long as I am able to do so. If I am incapacitated, then I give my agent full authority and discretion to make decisions about medical treatment for me within the context of the following values:

1. I want to die a natural death without having my life prolonged by machines or non-beneficial treatment.
2. I want my religious beliefs to be honored.
3. I want to die free of unnecessary pain and suffering even if pain medication will shorten my life.
4. I don't want to be a burden to my family.
5. I don't want my life prolonged, by any means, when this life has no more meaning for me.
6. I don't want artificial nutrition and hydration unless necessary for my comfort or to alleviate pain.

I trust my agent to make my medical decisions within the context of these values.

(b). It is my desire that my agent consent to and arrange for the administration of any type of pain relief, even though its use may lead to permanent damage, addiction, or even hasten the moment of, but not intentionally cause, my death.

(c) Regarding the decision to withhold or withdraw life-sustaining treatment, I desire that my agent act after allowing a reasonable period of time for observation and diagnosis.

(d) If I develop Alzheimer's disease, I would like all noninvasive life-prolonging treatments such as artificial nutrition, fluids, and antibiotics as long as I have the ability to meaningfully interact with my family and friends, and am physically independent, but I do not want highly intrusive treatments such as CPR, mechanical ventilation, or kidney dialysis. However, if I lose the capacity for meaningful interaction and physical independence, I then want only treatments that would make me more comfortable and free from pain. I would then not want artificial hydration or nutrition.

(e) **Authority to enforce PAHC** If my health care provider fails to honor my wishes as stated in this document, I direct and authorize my agent to take appropriate legal action, if necessary in my agent's judgment, to enforce my right of self determination as I have intended by executing this document. If my health care provider refuses to honor my agent's decisions, I empower my agent to direct my health care provider to transfer my care to another health care provider who will honor my wishes. If my health care provider thwarts, undermines, or does not honor to the fullest extent my durable power of the attorney for health care decisions or my agent's decisions, I further direct and empower my agent to initiate an action for battery against my health care provider.

5. **Inspection and Disclosure of Information Relating to My Physical or Mental Health.** My agent has the power and authority to do all of the following:

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

6. **Signing Documents, Waivers, and Releases.** When 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:

- (a) Documents titled or purporting to be a “Refusal to Permit Treatment” and “Leaving Hospital Against Medical Advice”; and
- (b) Any necessary waiver or release from liability required by a hospital or physician.

7. **Anatomical Gifts.** My agent shall have [        ] shall not have [        ] the power and authority to make a disposition of a part or parts of my body under the Uniform Anatomical Gift Act (Chapter 3.5, commencing with Section 7150) of Part 1 of Division 7 of the California Health and Safety Code).

8. **Disposition of Remains.** My agent shall have the authority to arrange for the following disposition of my remains under California Health and Safety Code sections 7100 and 7100.1. I direct that:

- [        ] my body be cremated.
- [        ] my body be buried.
- [        ] I have previously made arrangements through:

\_\_\_\_\_

*(name of mortuary or facility)*

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*(address)*

phone (\_\_\_\_\_) - \_\_\_\_\_

9. **Authorization of Autopsy.** I give \_\_\_\_\_ do not give \_\_\_\_\_ my agent the authority to authorize an autopsy under California Health and Safety Code section 7113.

10. **Prior Designations Revoked.** I revoke any prior durable power of attorney for health care only.

11. **Nomination of Conservator of Person.** If a conservator of the person is to be appointed for me, I nominate the first named agent to serve as conservator of the person, or the alternate agents above in the order designated. I grant to my conservator all the powers specified in the California Probate Code. My conservator shall serve in such capacity without bond, or if a bond is required, I request that a minimum bond be set. I revoke all prior conservatorship nominations.

## WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT (THE ATTORNEY IN FACT) THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. 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 AT THE TIME, 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 ANY STATEMENT OF YOUR DESIRES AND ANY 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 CANNOT 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 THE 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.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

### ADDITIONAL WARNINGS

THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE. YOUR AGENT MAY NEED THIS DOCUMENT IMMEDIATELY IN CASE OF AN EMERGENCY THAT REQUIRES A DECISION CONCERNING YOUR HEALTH CARE. EITHER KEEP THIS DOCUMENT WHERE IT IS IMMEDIATELY AVAILABLE TO YOUR AGENT AND ALTERNATE AGENTS OR GIVE EACH OF THEM AN EXECUTED COPY OF THIS DOCUMENT. YOU MAY ALSO WANT TO GIVE YOUR DOCTOR AN EXECUTED COPY OF THIS DOCUMENT.



**Acceptance by Physician:**

I, the undersigned, am the physician of \_\_\_\_\_, have read this power of attorney for health care and have had opportunity to discuss my patient's wishes in regard to end of life issues and health care treatment preferences. If my patient becomes incapacitated, I understand that it is my duty to follow a course of action which will implement the preferences expressed in this document in order to assure that the principal's wishes will be honored.

Date: \_\_\_\_\_  
signature

**UPDATING ADDRESSES OF MY HEALTH CARE AGENTS**

**ENTER MOST CURRENT ADDRESS WHERE INFORMATION HAS CHANGED AND SEND TO DOCTOR:**

\_\_\_\_\_ Alternate Agent: \_\_\_\_\_,  
residing at \_\_\_\_\_,  
the telephone number is ( ) \_\_\_\_\_.

\_\_\_\_\_ Alternate Agent: \_\_\_\_\_,  
residing at \_\_\_\_\_,  
the telephone number is ( ) \_\_\_\_\_.

\_\_\_\_\_ Alternate Agent: \_\_\_\_\_,  
residing at \_\_\_\_\_,  
the telephone number is ( ) \_\_\_\_\_.

\_\_\_\_\_ Alternate Agent: \_\_\_\_\_,  
residing at \_\_\_\_\_,  
the telephone number is ( ) \_\_\_\_\_.

\_\_\_\_\_ Alternate Agent: \_\_\_\_\_,  
residing at \_\_\_\_\_,  
the telephone number is ( ) \_\_\_\_\_.

\_\_\_\_\_ Alternate Agent: \_\_\_\_\_,  
residing at \_\_\_\_\_,  
the telephone number is ( ) \_\_\_\_\_.