DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

DECISION TO NAME SOMEONE TO SPEAK FOR ME

I, (your name) _____ (date of birth) _____ , appoint the following person(s) to make healthcare decisions for me when I am unable to make or communicate my own wishes:

Agent may not be the treating healthcare provider, an employee of the treating healthcare provider, or an employee, owner, director or officer of a facility, unless that person is a relative or is bound to you by common vows to a religious life.

PLEASE PRINT:

Name of Agent: _____ _____ Telephone _____ Telephone

Agent's address: _____ City _____ State/Zip _____

Name of First Alternate Agent: _____ _____ Telephone _____ Telephone

Agent's address: _____ City _____ State/Zip _____

Name of Second Alternate Agent: _____ _____ Telephone _____ Telephone

Agent's address: _____ City _____ State/Zip _____

This power of attorney for healthcare decisions shall become effective when I am unable to make decisions or unable to communicate my wishes regarding healthcare. This power of attorney for healthcare decisions shall not be affected by my subsequent disability or incapacity. Any durable power of attorney for healthcare decisions I have previously made is hereby revoked.

AUTHORITY GRANTED

My healthcare agent may:

1. Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition;
2. Make all arrangements for me at any hospital, treatment facility, hospice, nursing home or similar institution;
3. Employ or discharge healthcare personnel including physicians, psychiatrists, dentists, nurses, therapists or other persons who provide treatment for me;
4. Request, receive and review any information, spoken or written, regarding my personal affairs or physical or mental health including medical and hospital records, and execute any releases or other documents that may be required in order to obtain such information; and
5. Make decisions about organ and tissue donations, autopsy and the disposition of my body.

My agent shall authorize consent for the following special instructions:

I wish to be a donor for organs and tissues.

I have attached information about treatment choices I wish to have honored by my agent. ___ page(s) attached.

LIMITATIONS ON AUTHORITY GRANTED

My healthcare agent may not:

1. Exceed the powers set out in writing in this document; *or*
2. Revoke any existing Living Will Declaration I may have.

X _____
signature date

Notary Public: Notary Seal:

STATE OF _____ COUNTY OF _____

This instrument was acknowledged before me this _____ day of _____ (month, year)

Signature of Notary _____

or

Witnesses: (witnesses may not be the agent or a relative, or beneficiary of the principal)

X _____ Date: _____
(Signature)

X _____ Date: _____
(Signature)

This document is based on Kansas Statutes Annotated, (58-625 through 632)
Additional forms and information are available through

Wichita Medical Research & Education Foundation
3306 E. Central, Wichita, KS 67208
316-686-7172

www.wichitamedicalresearch.org

Reprinted 10/2011