DURABLE POWER OF ATTORNEY
For Health Care

I, _____ , of _____ County, Pennsylvania, appoint the person named below to be my Health Care Agent to make health and personal care decisions for me.

Effective immediately and continuously until my death or revocation signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my Health Care Agent, upon my Agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act (HIPAA) regulation of 1996.

The remainder of this document will take effect when and only when I lack the ability to UNDERSTAND, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My Health Care Agent may not delegate the authority to make decisions.

MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS SUBJECT TO THE HEALTH CARE TREATMENT INSTRUCTIONS THAT FOLLOW (cross out and initial any powers you do not want to give your Health Care Agent):

1. To authorize, withhold or withdraw medical care and surgical procedures.
2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines arteries or veins.
3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreement for my care and health insurance for my care, including hospice and/or palliative care.
4. To hire and fire medical, social service and other support personnel responsible for my care.
5. To take any legal action necessary to do what I have directed.
6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out –of –hospital DNR order, and sign any required documents and consents.
7. To give consent for organ/tissue donation.

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following Health Care Agent:

_____

(Name and Relationship)

_____

(Address)

Telephone Number: Home: _____ Work: _____ Cell: _____

E-mail: _____

NOTE: IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES AND VALUES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT. YOU MAY NOT APPOINT YOUR DOCTOR OR OTHER HEALTH CARE AGENT UNLESS RELATED TO YOU BY BLOOD, MARRIAGE OR ADOPTION

(Continued on other side)

If my Health Care Agent is not readily available or if my Health Care Agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below, in the order named:

First Alternative Health Care Agent:

_____

(Name and Relationship)

_____

(Address)

Telephone Number: Home: _____ Work: _____ Cell: _____

E-mail: _____

Second Alternative Health Care Agent:

_____

(Name and Relationship)

_____

(Address)

Telephone Number: Home: _____ Work: _____ Cell: _____

E-mail: _____

GUIDANCE FOR HEALTH CARE AGENT

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.): _____

_____

_____

_____

_____

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my Health Care Agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness.

Initials _____ I agree

Initials _____ I disagree

Having carefully read this document, I have signed it this _____ day of _____ , 2_____ , revoking all previous Health Care Powers of Attorney.

Print Name: _____

Signature: _____

Address: _____

Social Security Number: _____ DOB: _____

Witness: _____

Witness: _____