DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

GENERAL STATEMENT OF AUTHORITY GRANTED:

I, _____, (DOB) _____, designate and appoint:

Name of Agent: _____ Phone: _____

Address: _____ Cell Phone: _____

Alternate Agent: _____ Phone: _____

Address: _____ Cell Phone: _____

to be my agent for health care decisions and pursuant to the language stated below on my behalf to:

(1) Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition; and to make decisions about organ donation, autopsy and disposition of the body;

(2) Make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institutions; to employ or discharge health care personnel to include physicians, psychiatrists, psychologist, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care as the agent shall deem necessary for my physical, mental and emotional well being; and

(3) Request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute any releases of other documents that may be required in order to obtain such information.

In exercising the grant of authority set forth above, my agent for healthcare decisions shall: be guided by my Healthcare Directive(s); or be guided by any previous discussions if no directives are established.

LIMITATIONS OF AUTHORITY:

(1) The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney of health care decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.

(2) The agent shall be prohibited from authorizing consent for the following items: _____

_____

(3) This durable power of attorney for health care decision shall be subject to the additional following limitations: _____

_____

EFFECTIVE TIME: This power of attorney for health care decisions *shall become effective when I am unable to make decisions or unable to communicate my wishes regarding healthcare.* This power of attorney for health care decisions shall not be affected by my subsequent disability or incapacity.

REVOCATION: Any durable power of attorney for health care decisions I have previously made is hereby revoked. This durable power of attorney shall be revoked by an instrument in writing executed, witnessed or acknowledged in the same manner as required herein or set out another manner of revocation, if desired.

EXECUTION: Executed this day _____ (date) at _____ (county), Kansas

PRINCIPAL: _____ (signature)

WITNESSES: This document must be: (1) witnessed by two individuals of lawful age who are not the agent, not related to the principal by blood, marriage or adoption, not entitled to any portion of principal's estate and not financially responsible for principal's health care; or (2) acknowledged by a notary public.

Witness: _____ Address: _____

Witness: _____ Address: _____

(OR) Notary SEAL:

STATE OF _____ COUNTY OF _____

This instrument was acknowledged before me on_____ By_____

Signature of Notary_____ Appt Expires_____

HUTCHINSON
REGIONAL HEALTHCARE SYSTEM