

Durable Power of Attorney for Healthcare Decisions



I, _____ DOB _____ SS# _____ of _____
(please print)
(address) _____

If I am unable to make healthcare decisions myself, appoint the person named below to be my healthcare agent to make any and all healthcare decisions for me, including accepting or refusing any treatment, service or procedure to diagnose or treat my physical or mental condition. It includes decisions to provide, withhold or withdraw life-sustaining treatment and other rights as indicated on the reverse of this document. I expect my healthcare agent to make decisions on my behalf in accordance with my wishes. In the event my wishes are not clear or if a situation arises that I did not anticipate, my healthcare agent is authorized to make healthcare decisions in my best interest.

(initial, if applicable)	This durable power of attorney becomes effective when two physicians certify that you are incapacitated and unable to make and communicate healthcare choices. You may chose to have one physician, instead of two, determine whether you are incapacitated. If you want to exercise this option, allowing one physician to determine whether you are incapacitated, initial this box.
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Primary Agent:

Name: _____ Phone: _____
Address: _____

Alternate Agent (optional): If the previously named person is unable, unwilling, or unavailable to act as my healthcare representative/agent, I appoint the following person as my alternate health care representative/agent:

Name: _____ Phone: _____
Address: _____

My Signature: _____ Date: _____

<p>Notarization: On this ____ day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____ State of _____, on the date written above.</p> <p>Notary Public: _____ Commission expires: _____</p>	
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Revocation: I revoke this Durable Power of Attorney: _____			
	Signature		Date
Witness _____	Signature	_____	Date
	Date	Witness: _____	Date
	Date		Date

Durable Power of Attorney for Healthcare Decisions

The Durable Power of Attorney for Healthcare Decisions allows you to appoint someone else to make healthcare decisions on your behalf if you are unable to make decisions or communicate your wishes. The person you appoint is called your agent.

Your healthcare agent should be someone who understands your goals and values and someone whom you trust to carry out your wishes.

You may choose a family member or friend who is at least 18 years old. Your agent cannot be a doctor, an employee of a doctor or an owner, operator or employee of a healthcare facility in which you live, unless you are related. Make sure that the person is willing to act as your agent and talk candidly about your end-of-life wishes so there are no misunderstandings.

Your agent may make healthcare decisions for you only if you are physically or mentally unable to do so yourself.

Missouri law requires two doctors to declare a person incapacitated, unless you specify otherwise. The durable power of attorney section on the form allows you to choose whether you want one or two doctors to determine whether your agent should make decisions on your behalf.

Acknowledgment

By completing this durable power of attorney, I authorize my agent to make all decisions for me regarding my healthcare. This includes the power to withdraw any type of healthcare, treatment or procedure, even if I may die in the process. I expect my agent to follow my healthcare choices directive. My agent has the power to:

- Consent, refuse or withdraw consent to artificially supplied nutrition and hydration.
- Make all necessary arrangements for healthcare on my behalf. This includes admitting me to any hospital, psychiatric treatment facility, hospice, nursing home or other healthcare facility.
- Request, receive and review my medical and hospital records.
- Carry out my wishes regarding autopsy and organ donation and decide what should be done with my body.

My agent under this durable power of attorney will not incur any personal financial liability. The agent also should not be compensated for services performed for me. However, the agent shall be reimbursed for reasonable expenses that are part of my care.

This is a Durable Power of Attorney and the authority of my attorney in fact, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

Signature: _____ Date: _____