DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

I, _____, being of sound mind, do hereby voluntarily make this designation:

APPOINTMENT OF PATIENT ADVOCATE

I designate _____, my _____ (Wife, Husband, Brother, Friend, etc.), Who resides at _____ as my patient advocate. If this person cannot or will not serve as my patient advocate, then I designate _____, my _____ (Wife, Husband, etc), who resides at _____to serve as my patient advocate.

My patient advocate must formally accept this appointment, by signature, before being able to serve as my advocate. I have discussed this appointment with the person(s) who I have designated as my patient advocate and/or successor patient advocate.

GENERAL POWERS

My patient advocate or successor patient advocate shall have the power to make decisions regarding my care, custody, and medical treatment if my attending physician and another physician or licensed psychologist, psychiatrist or doctor, determine I am unable to participate in my own medical treatment decisions.

In making decisions, my patient advocate shall, as nearly as possible, try to follow my previously expressed wishes, whether I have stated them orally, in a living will, or in this designation.

My patient advocate shall have full authority to consent to or refuse treatment on my behalf, to arrange medical and necessary services for me, including admission to a hospital or nursing care facility, and to pay for such services with my funds.

My patient advocate shall have access to any of my medical records to which I have a right, immediately upon signing an Acceptance. This shall serve as a release under the Health Insurance Portability and Accountability Act.

Upon signing an Acceptance of Designation of Patient Advocate, my advocate shall have access to my birth certificate and other legal documents needed to apply for any insurance benefit or governmental assistances as my patient advocate may deem necessary, including but not limited to Medicare, Medicaid, and any other government or insurance benefit program.

POWER REGARDING MENTAL HEALTH TREATMENT

I expressly authorize my patient advocate to make decisions concerning the following treatments if a physician and a mental health professional determine I cannot give informed consent for mental health care.

_____

Sign here if you wish to give the patient advocate this authority.

POWER REGARDING LIFE-SUSTAINING TREATMENT

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my death. My patient advocate can sign a do-not-resuscitate declaration for me. My patient advocate can withdraw administration of food, water, medication and treatment.

_____

Sign here if you wish to give the patient advocate this authority.

Check boxes per your wishes:
I give my patient advocate authority to make determinations regarding my:

☐ outpatient therapy

☐ my admission as a formal voluntary patient to a hospital to receive inpatient mental health services.

☐ I reserve the right to give three (3) days notice of intent to leave any hospital or facility.

☐ my admission to a hospital to receive inpatient mental health services

☐ psychotropic medication

☐ electro-convulsive therapy (ECT)

☐ I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days notice of my intent to leave a hospital if I am a formal voluntary patient.

_____

Sign here if you wish to give the patient advocate this authority

POWER REGARDING ORGAN DONATION

I expressly authorize my patient advocate to make a gift of the following of my organs (check those boxes that reflect your wishes):

☐ any needed organs or body parts for the purposes of transplantation, therapy, medical research, or education

☐ only the following listed organs or body parts for the purposes of transplantation, therapy, medical research, or education:

_____

_____

☐ my entire body for anatomical study

☐ I wish my gift to go to _____

Specify the name of organization or person

The gift is effective upon my death. Unlike other powers I give to my patient advocate, this power remains after my death.

_____

(Sign here if you wish to give the patient advocate this authority)

STATEMENT OF WISHES

My patient advocate has authority to make decisions in a wide variety of circumstances. In this document, I can express general wishes regarding conditions such as terminal illness, permanent unconsciousness, or other disability; specify particular types of treatment I do or do not want in such circumstances; or I may state no wishes at all. If you have chosen to give your patient advocate power concerning mental health treatment, you can also include specific wishes about mental health treatment such as a preferred mental health professional, hospital or medication.

A. My wishes are as follows:

_____
_____
_____
_____
_____
_____

I acknowledge and reserve the right to change my mind at any time by communicating, in any manner, that this designation does not reflect my wishes.

It is my intent no one involved in my care shall be liable for honoring my wishes as expressed in this designation or for following the directions of my patient advocate.

A copy of this document shall have the full force and effect as the original, and electronic signatures shall be deemed as valid as an original.

SIGNATURE

I hereby represent that I am of sound mind and have read and understand the contents of this document, and wish for my patient advocate to have the above powers to act on my behalf.

x_____

PATIENT'S SIGNATURE DATE:_____

Patient's Address:

_____

_____

_____

STATEMENT REGARDING WITNESSES

The following two adult witnesses, who are not named in my will, who are not my spouse, parent, child, grandchild, brother or sister; who are also not my physician or my patient advocate; who are not an employee of my life or health insurance company, an employee of a home for the aged where I reside, an employee of community mental health program providing me services, or an employee at the health care facility where I am now.

STATEMENT AND SIGNATURE OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The patient-signator appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud, or undue influence.

WITNESS NO. 1	WITNESS NO. 2
x_____	_____
(Print name)	(Printed name)
Witness Address:	Witness Address:
_____	_____
_____	_____
_____	_____

ACCEPTANCE BY PATIENT ADVOCATE

(1) This designation shall not become effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable by law. If this patient advocate designation includes the authority to make an anatomical gift as described in the Designation of Patient Advocate, above, the authority to do so shall remain exercisable after the patient's death, in accordance with the patient's wishes.

(2) A patient advocate shall not exercise powers concerning the patient's care, custody, and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

(3) This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would likely result in the pregnant patient's death.

(4) A patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die only if (1) the patient has expressed, in a clear and convincing manner, the patient's wishes to withhold or withdraw treatment and (2) directly allowing the advocate authority to make such a decision on behalf of the patient.

(5) A patient advocate shall not receive compensation for the performance of services as a patient advocate, but may be reimbursed for actual and necessary expenses incurred.

(6) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries in accordance with the patient's best interests. .

(7) A patient may revoke his or her designation at any time or in any manner.

(8) A patient may waive his or her right to revoke the patient advocate designation regarding power to make mental health treatment decisions.

(9) If the patient waives his or her right to revoke mental health treatment, such waiver will be delayed for 30 days after the patient communicates his or her intent to revoke.

(10) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate the intent to revoke acceptance of designation as the patient's advocate.

(11) In accepting to serve as the patient advocate, I acknowledge and understand that the patient for whom I am an advocate has certain treatment rights, which I will do my best to serve.

I, _____[Insert Your Name], understand the above conditions and hereby accept the appointment and agree to serve as patient advocate for _____ [Insert Patient Name]. I agree to perform the duties of patient advocate to the best of my ability.

x_____.
PATIENT ADVOCATE
Dated: _____