

Medical Durable Power of Attorney for Healthcare

By this document I intend to create a Medical Durable Power of Attorney for Healthcare, which shall take effect immediately upon signing and the authority shall not be affected by my subsequent incapacity to make my own healthcare decisions.

<p>Appointment of Primary Agent</p>	<p>I, _____, the principal, hereby revoke any existing Medical Durable Power of Attorney for Healthcare and appoint:</p> <p>(Print or type your name)</p> <p>_____ Name of Primary Agent</p> <p>_____ Agent's Home Address</p> <p>_____ Agent's Home Telephone Number/Work Telephone Number as my Agent to make healthcare decisions for me if and when I am unable to make my own healthcare decisions.</p>
<p>Successor Agents</p>	<p>If my primary Agent is not available at the time a decision is to be made or is unable to act as my Agent, then I appoint the following individual(s) to serve in the order listed below:</p> <p>2. Name: _____ Home Address: _____ Telephone numbers: _____</p> <p>3. Name: _____ Home Address: _____ Telephone numbers: _____</p>
<p>Duties of Agent</p>	<p>This document gives my Agent the absolute discretion to give, withhold or withdraw consent, to any healthcare, treatment, procedure or test, including surgery and the withdrawal of artificial nutrition and hydration. My Agent also has the authority to talk with healthcare personnel; obtain copies of my medical records; employ or discharge health care personnel; grant releases to hospital staff, physicians, nurses or other personnel who rely on my Agent's instructions; make arrangements for any hospital, nursing home or similar establishment; make transportation and residential arrangements; and sign forms necessary to carry out those decisions. The authority conferred upon my agent shall eliminate the need for appointment of a guardian. However, should any proceeding commence for appointment of a guardian, I nominate my agent to serve as guardian without bond.</p>
<p>Basis for Decisions</p>	<p>I realize that my healthcare Agent may need to make difficult decisions for me. I want my healthcare Agent to make decisions in accordance with the instructions I have made known to my Agent. If my Agent does not know what I would decide, then my Agent shall make the decision he or she thinks is in my best interests.</p>
<p>Principal Can Make Changes</p>	<p>I retain the right to revoke or amend this document and to substitute other agents in place of those named above. Amendments to this document shall be made in writing by me personally, and not by any Agent named herein.</p>
<p>Agent Not Financially Responsible</p>	<p>In no event shall my Agent incur personal financial liability for signing contracts and forms in order to accomplish such purposes on my behalf.</p>
<p>Agent is Released from Claims of Wrongdoing</p>	<p>My Agent and my Agent's estate, heirs, successors and assigns are hereby released and forever discharged by me, my estate, my heirs, successors and assigns from all liability and from all claims arising out of the acts or omissions of my Agent except for Agent's willful misconduct or gross negligence.</p>

<p>Others Involved in Care are Released from Certain Claims</p>	<p>Third parties shall accept as binding the instructions and decisions of my Agent regarding my medical treatment. No person or medical facility or institution shall incur any liability to me or to my estate by complying with my Agent's instructions. My Agent is authorized to execute consents, waivers, and releases of liability on my behalf and on behalf of my estate to all medical personnel who comply with my Agent's instructions. Furthermore, I authorize my Agent to indemnify and hold harmless, at my expense, any third party who accepts and acts under this Durable Medical Power of Attorney for Healthcare, and I agree to be bound by any such indemnity entered into by my Agent.</p>
<p>Access to Medical Records and Other Personal Information HIPAA Release of Authority</p>	<p>My agent shall be treated as I would regarding the use and disclosure of my individual identifiable health information or other medical records. This release applies to any information governed by HIPAA, 42 USC 1320d, to all health care providers, insurance companies and the Medical Information Bureau, Inc. This authority given my agent has no expiration date and shall expire only if I revoke this authority in writing.</p>
<p>Signature of person creating this document (Principal)</p>	<p>Principal _____ Date _____</p>

(Optional But Recommended) Colorado Law does not require signatures of either 2 witnesses or a notary, however it is recommended and may make this document more acceptable in other states.]

Witness: _____ Date: _____
 Signature: _____
 Home Address: _____

Witness: _____ Date: _____
 Signature: _____
 Home Address: _____

STATE OF COLORADO

County of _____

Subscribed and sworn to or affirmed before me by _____, the principal, and _____, and _____, witnesses, as the voluntary act and deed of the principal, this _____ day of _____, in the year _____.

My commission expires: _____.

Witness my hand and official Seal.

Notary Public Signature: _____

Copies of this document have been given to:

1. Named Agents _____
2. Physician(s) _____
3. _____
4. _____
5. _____
6. _____

Developed by the Advance Care Planning Task Force