Durable Medical Power of Attorney

1. Principal

Name:

Address:

Phone Number:

2. Agent

Name of Agent:

Address of Agent:

Phone Number of Agent:

3. Alternate Agent (Optional)

Name of Alternate Agent:

Address of Alternate Agent:

Phone Number of Alternate Agent:

4. Grant of Authority

I give my Agent the power and authority to make health care decisions for me if I am unable to make them for myself, including but not limited to the following:

- Consenting, refusing, or withdrawing any type of health care, medical treatment, or procedure;
- Hiring and firing medical personnel;
- Gaining access to medical records;
- Making decisions about admission, transfer, or discharge from any hospital or care facility.

5. Special Instructions (Optional)

6. Effective Date and Duration

This Durable Medical Power of Attorney becomes effective upon my incapacity as determined by my physician and shall remain in effect until revoked in writing by me.

7. Signature

_____

Principal's Signature:

Date:

_____

Agent's Signature:

Date:

8. Witness or Notary (if required by state law)

Name of Witness:

Signature of Witness:

Date: