

**DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE DECISIONS**

**CREATION OF DURABLE POWER OF ATTORNEY**

I, \_\_\_\_\_, date of birth \_\_\_\_\_, of \_\_\_\_\_ (city),  
\_\_\_\_\_ (county), and \_\_\_\_\_ (state), designate and appoint

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

as my agent to make health care decisions for me as authorized in this document. The decision of my agent shall be honored. In the event the above-named agent is unwilling or unable to act as my agent, I hereby appoint the following person(s) to so serve, in the order listed below. (If more than one agent is appointed to serve jointly, I understand that they must be in agreement on the health care decisions made on my behalf.)

First alternate agent:

Second alternate agent:

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Telephone \_\_\_\_\_

**GENERAL STATEMENT OF AUTHORITY GRANTED**

Pursuant to the language stated below, on my behalf my agent may:

- (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 my body;
- (2) Make all necessary arrangements at any hospital, psychiatric hospital, or psychiatric treatment facility, hospice, nursing home, or similar institution; to employ or discharge health care personnel to include physicians, psychiatrists, psychologists, 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;
- (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 or other documents that may be required in order to obtain such information; and
- (4) Execute any appropriate authorizations for the use or disclosure of my protected health information.

In exercising this grant of authority, my agent shall be guided by my expressed desires, including the following:

*(Insert any special instructions to be followed by the agent, such as a living will declaration, statements relating to the principal's meaningful quality of life, or other guidance.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIMITATIONS OF AUTHORITY**

The powers of my agent shall be limited to the extent set out in writing in this durable power of attorney for health care decisions and shall not include the power to revoke or invalidate any previously existing or subsequent declaration made in accordance with the Natural Death Act or any common law living will declaration.

The agent shall be prohibited from authorizing consent for the following items:

\_\_\_\_\_

\_\_\_\_\_

This durable power of attorney for health care decisions shall be subject to the additional following limitations:

\_\_\_\_\_

\_\_\_\_\_

**WHEN EFFECTIVE**

This durable power of attorney for health care decisions shall become effective (initial one):

\_\_\_\_\_ Immediately and shall not be affected by my subsequent disability, incapacity, or death; or

\_\_\_\_\_ Upon the occurrence of my disability or incapacity.

**REVOCATION**

Any durable power of attorney for health care decisions which I have previously made is hereby revoked. This durable power of attorney for health care decisions may be revoked by any instrument in writing executed, witnessed, or acknowledged in the same manner as this document.

**EXECUTION**

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, at \_\_\_\_\_, Kansas.

\_\_\_\_\_  
Principal

This document must be dated and signed in the presence of two witnesses **OR** acknowledged by a notary public.

(1) Witnesses – 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 the principal’s estate; and not financially responsible for principal’s health care.

Witness \_\_\_\_\_

Witness \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

**OR**

(2) STATE OF KANSAS )  
) ss:  
COUNTY OF \_\_\_\_\_ )

This instrument was acknowledged before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

Signature of Notary Public \_\_\_\_\_

My appointment expires: \_\_\_\_\_

**Discuss this document and your treatment preferences with your physician(s), family members, and designated agent, and provide them with a signed copy or photocopy.**