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:

Name _____

Address _____

_____

Telephone _____

Second alternate agent:

Name _____

Address _____

_____

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.