

HEALTH CARE POWER OF ATTORNEY

I, _____ of _____, _____, _____ voluntarily appoint _____ of _____, _____, _____ as my attorney-in-fact and health care representative to act for me in all matters of my health care in accordance with Indiana Code §16-36-1 and §30-5 et. seq., except as otherwise specified below.

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss care decisions with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.

This appointment is to be exercised in good faith and in my best interests subject to the following terms and conditions: _____.

If protective proceedings for my person or estate are commenced, I nominate my health care attorney-in-fact as my guardian.

I wish to donate only the following organs or parts: _____, for any legally authorized purpose.

This appointment becomes effective if I am incapable of consenting to my own health care. I do authorize my health care representative hereby appointed to delegate decision-making power to another.

Dated this _____ day of _____, _____.

Principal's Signature

Principal's Name

Principal's Address

City

County

State

Zip Code

Principal's Date of Birth

Principal's Social Security Number

NOTARY ACKNOWLEDGEMENT

State of _____)
County of _____) **(Seal)**

The foregoing instrument was acknowledged before me this _____ day of _____, 20____, by the undersigned, _____, who is personally known to me or satisfactorily proven to me to be the person whose name is subscribed to the within instrument.

Signature

Notary Public

My Commission Expires: _____

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GENERAL INSTRUCTIONS

WHAT IS A MEDICAL POWER OF ATTORNEY?

A Power of Attorney for Health Care allows you to name a health agent, someone who will make health decisions for you if you cannot. Your health care agent will ensure that your health care providers give you the care you wish to receive. You can also require that your health care agent communicate in any manner with you about any specific proposed health care.

WHEN IS IT NEEDED?

A Medical Power of Attorney or POAs are commonly used when someone wants the peace of mind that their health decisions will be made by someone they trust. The Health Care Agent steps into your shoes and can access your medical information and make decisions on your behalf.

You may need a Medical POA if you are:

- Over the age of 18 years old
- Military personnel being deployed overseas
- Traveling abroad for an extended time
- Diagnosed with a chronic condition or life threatening illness
- Growing wiser and older but concerned about your current health
- Married and want your spouse to have legal authority over property you own
- Participate in extreme sports or activities that put your health at risk
- Engaged in a high risk profession (i.e. firefighter or member of police force)

OTHER NAMES

People may call a Medical POA by:

- Advance Medical Directive
- Durable Power of Attorney for Health Care
- Health Care Advance Directive
- Health Care Power of Attorney
- Health Care Proxy
- Medical Durable Power of Attorney
- Power of Attorney for Health Care

WHAT SHOULD BE INCLUDED

A Medical Power of Attorney should generally address the following:

- **Who** do you trust to make healthcare decisions for you
- **What** kind of decisions can your health care agent make on your behalf
- **When** can your health care agent begin making medical decisions for you
- **Why** you prefer to continue or discontinue artificial life sustaining treatment

You can specify whether your health care agent can make these additional decisions on your behalf:

- **Mental Health Treatment**
 - Admit you into an institution for mental diseases or state treatment facility
 - Give consent to experimental mental health research or psychosurgery
- **Nursing Homes**
 - Admit you into a nursing home
 - Admit you into a community-based residential facility
- **Feeding Tubes**
 - Withhold or withdraw a feeding tube
- **Pregnant Women**
 - Health care agent may or may not make healthcare decisions for you if they know you are pregnant
- **Medical Records**
 - Request, receive, and review all medical records
 - Grant medical releases
 - Consent to disclosure of info
- **Medical Treatment**
 - Initiate or withhold a procedure
 - Start or stop a medical service
 - Modify medical care
 - Employ and discharge healthcare personnel
- **Anatomical Gifts**
 - Arrange or prohibit organ donations or donate your body