State of Indiana

HEALTH CARE POWER OF ATTORNEY

I, _____ [Principal name] of _____ [Address] voluntarily appoint _____ [Agent name] of _____ [Address] 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.

Agent's Authority (CHECK if applicable. CROSS OUT if not applicable.)

☐ 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be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.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 heath 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: _____).

Guardian Nomination (CHECK if applicable. CROSS OUT if not applicable.)

☐ If protective proceedings for my person or estate are commenced, I nominate (Check one) ☐ my health care attorney-in-fact ☐ _____ [Name] of _____ [Address] as my guardian.

Donation of Organs (Check one)

☐ I do NOT wish to make an organ or tissue donation, and do not want my health care attorney-in-fact to do so.

☐ I wish to donate ANY needed organs or parts for: (Check one)

- ☐ Only the following purposes: _____
- ☐ Any legally authorized purpose.

☐ I wish to donate ONLY the following organs or parts: _____, for: (Check one)

- ☐ Only the following purposes: _____
- ☐ Any legally authorized purpose.

This appointment becomes effective (Check one) ☐ immediately ☐ If I am incapable of consenting to my own health care. I (Check one) ☐ do not ☐ do authorize my health care representative hereby appointed to delegate decision-making power to another.

Dated this _____ day of _____, 20_____.

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

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: _____