DURABLE HEALTH CARE POWER OF ATTORNEY

I, _____________________, of __________ County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 2024 1936), the regulations promulgated thereunder and any other State or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.

The remainder of this document will take effect immediately. My health care agent may delegate the authority to make decisions.

MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS (CROSS OUT ANY POWERS YOU DO NOT WANT TO GIVE YOUR HEALTH CARE AGENT):

1. To authorize, withhold or withdraw medical care, dental care, diagnostic and other testing, sedation, anesthetic and surgical procedures, routine and otherwise.

2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.

3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.

4. To hire and fire medical, social service and other support personnel responsible for my care.

5. To take any legal action necessary to do what I have directed.

6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.
APPOINTMENT OF HEALTH CARE AGENT

I appoint the following health care agent: ________________________, MY __________ (Name and relationship)
Address: __________________________________________________________________________________________

Telephone Number: Home ____________________ Work__________________

E-MAIL: __________________________________________________________________________________________

IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES AND VALUES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT.

NOTE THAT YOU MAY NOT APPOINT YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER AS YOUR HEALTH CARE AGENT UNLESS RELATED TO YOU BY BLOOD, MARRIAGE OR ADOPTION.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative health care agents.)

First Alternative health care agent ________________________ (Name and relationship)
Address: __________________________________________________________________________________________

Telephone Number: Home ____________________ Work__________________

E-MAIL: __________________________________________________________________________________________

GUIDANCE FOR HEALTH CARE AGENT

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows:

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness. I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.
In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

I (_____ do (_____ do not want cardiac resuscitation.

I (_____ do (_____ do not want mechanical respiration.

I (_____ do (_____ do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).

I (_____ do (_____ do not want blood or blood products.

I (_____ do (_____ do not want any form of surgery or invasive diagnostic tests.

I (_____ do (_____ do not want kidney dialysis.

I (_____ do (_____ do not want antibiotics.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome.

I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

Initials _______ I agree
Initials _______ I disagree

LEGAL PROTECTION

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my agents health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.
SIGNATURE

Having carefully read this document, I have signed it this _________ day of
______________, 20____, revoking all previous health care powers of attorney and health
care treatment instructions.

___________________________________________
Signature of Principal

WITNESS: ________________________
WITNESS: ________________________

NOTARIZATION
On this _______day of______________, 20____, before me, the undersigned officer,
personally appeared___________________ and ______________________ known to me or
satisfactorily proven to be witnesses to the signature of the principal of the foregoing
instrument and each acknowledged that they are 18 years of age or older, that neither is a
health care provider nor an employee of a health care provider to the principal and that each
witnessed the principal execute the document in each other’s presence and the principal,
upon personal observation, appeared to be lucid, in control of his/her faculties, to understand
the nature of the within instrument and to be acting voluntarily in affixing his/her signature
thereto.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the
County of ______________, State of __________ the day and year first above written.

____________________________         ________________________
Notary Public                              My commission expires

NOTARIZATION
On this_______day of ______________, 20____, before me, the undersigned officer,
personally appeared ___________________, known to me or satisfactorily proven to be the
person whose name is subscribed to the foregoing instrument and acknowledged that he/she
executed the same as his/her free act and deed. Upon personal observation, he/she appeared
to be lucid, in control of his/her faculties, to understand the nature of the within instrument,
and to be acting voluntarily in affixing his/her signature thereto.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the
County of ______________, State of __________ the day and year first above written.

____________________________         ________________________
Notary Public                              My commission expires