# 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. 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 when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My health care agent may not delegate the authority to make decisions.

My health care agent has all of the following powers subject to the health care treatment instructions that follow in Part III (cross out any powers you do not want to give your health care agent):

1 To authorize, withhold or withdraw medical care and surgical procedures.

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:

Health Care Agent (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: _____

Second Alternative Health Care Agent (name and relationship):_____

Address: _____

Telephone Number: Home_____ Work _____

E-Mail: _____

## Guidance for Health Care Agent Goals

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.):

_____
_____
_____
_____
_____
_____

In order to help understand what you want from medical treatment, place your initials in the box which reflects your values. Remember that these are used only to help inform your physician and guide your Health Care Agent in making health care decision if you are not able to communicate your wishes:

| If I am in these situations: | I want to continue living like this | I'm not sure | I do not want to live like this |
|---|---|---|---|
| Cannot understand what I read or cannot carry on a conversation due to dementia or brain injury. | | | |
| Need to stay in a nursing home for the rest of my life. | | | |
| Need somebody to take care of me (bathing, feeding, using the bathroom, and getting dressed) for the rest of my life. | | | |
| Can't go outside on my own for the rest of my life. | | | |

## Severe Brain Damage or Brain Disease

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 _____

## Health Care Treatment Instructions in the Event of End-Stage Medical Condition or Permanent Unconsciousness

## (Living Will)

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as an irreversible coma or an irreversible vegetative state and there is no realistic hope of significant recovery, all of the following apply (cross out any treatment instructions with which you do not agree):

1 I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.

2 I direct that all life-prolonging procedures be withheld or withdrawn.

3 I specifically do not want any of the following as life prolonging procedures: (If you wish to receive any of these treatments, write "I do want" after the treatment)

heart-lung resuscitation (CPR)_____
mechanical ventilator (breathing machine) _____
dialysis (kidney machine) _____
surgery _____
chemotherapy_____
radiation treatment _____
antibiotics _____

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery. (Initial only one statement).

## Tube Feedings

_____I want tube feedings to be given

## No Tube Feedings

_____I do not want tube feedings to be given.

## Health Care Agent's Use of Instructions
## (Initial one option only)

_____My health care agent must follow these instructions.

**OR**

_____These instructions are only guidance. My health care agent shall have final say and may override any of my instructions. (Indicate any exceptions)

_____

_____

If I did not appoint a health care agent, these instructions shall be followed.

## 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 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.

## Organ Donation (Initial one option only)

_____I consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. (Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.)

_____

_____

**OR**

_____I do not consent to donate my organs or tissues at the time of my death.

## 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.

_____

(Sign full name here for health care power of attorney and health care treatment instructions.)

WITNESS: _____

WITNESS: _____

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)

## Notarization (optional)

(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.)

On this _____ day of _____ , 20___ , before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

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