

INSTRUCTIONS FOR HEALTH CARE POWER OF ATTORNEY

A power of attorney form is a document which is used to allow one person to give authority to another person to act on their behalf. The person signing the power of attorney grants legal authority to another to "stand in their shoes" and act legally for them. The person who receives the power of attorney is called an attorney-in-fact. This title and the power of attorney form does not mean that the person receiving the power has to be a lawyer. Power of attorney forms are useful documents for many occasions. They can be used to authorize someone else to sign certain documents if you can not be present when the signatures are necessary. Traditionally, property matters were the type of actions handled with powers of attorney. Increasingly, however, people are using a specific type of power of attorney to authorize other persons to make health care decisions on their behalf in the event of a disability which makes the person unable to communicate their wishes to doctors or other health care providers. This broad type of power of attorney is called a health care power of attorney. It is different from durable power of attorney, which gives another person the authority to sign legal papers, transact business, buy or sell property, etc. but is intended to remain in effect even if a person becomes disabled or incompetent. A durable power of attorney does not confer authority on another person to make health care decisions on someone else's behalf. Only a health care power of attorney can do that. Nearly all states have passed legislation that specifically authorizes health care powers of attorney or some similar legal document. In some states, they are called Appointment of Health Care Agent; in others, they are referred to as a Health Care Proxy. This form is officially titled Health Care Power of Attorney and Appointment of Health Care Agent and Proxy, and is designed to be legally valid in all states.

This Health Care Power of Attorney is intended to be used to confer a very powerful authority to another person. In some cases, this may actually mean that you are giving that other person the power of life or death over you. This is not a power that should be conferred lightly. Very serious thought should be given to both who you appoint as your health care attorney-in-fact (the person you authorize to act on your behalf) and to any specific directions that you may want to give to that person regarding health care decisions.

To complete this form, fill in the following:

1. Name of person granting power (principal)
2. Address of principal
3. City of principal
4. State of principal
5. Name of person granted power (attorney-in-fact)
6. Address of attorney-in-fact
7. City of attorney-in-fact
8. State of attorney-in-fact
9. State in which the health care power of attorney is signed
10. Signature of principal if the previous statements apply to this power of attorney
11. Additional terms and conditions of this health care power of attorney
12. Date of signing of power of attorney
13. Signature of principal (signed in front of Notary Public)
14. Printed name of witness #1
15. Printed name of witness #2
16. Signature and address of witness #1 (signed in front of Notary Public)
17. Signature and address of witness #2 (signed in front of Notary Public)

The following should be completed by the Notary Public:

18. State where document is notarized
19. County where document is notarized
20. Date when document is notarized
21. Name of principal
22. Name of witness #1
23. Name of witness #2
24. Signature of Notary Public
25. County of Notary Public
26. State of Notary Public
27. Date Notary Public commission expires
28. Seal of Notary Public

The following should be completed by the person you have appointed as attorney-in-fact. (signature need not be notarized)

29. Signature of attorney-in-fact

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I, _____, residing at _____,
City of _____, State of _____, appoint the
following person as my attorney-in-fact for health care decisions, my health care agent, and confer upon this person
my health care proxy. This person shall hereafter referred to as my "health care representative":

_____, residing at _____,
City of _____, State of _____,

I grant my health care representative the maximum power under law to perform any acts on my behalf regarding
health care matters that I could do personally under the laws of the State of _____
including specifically the power to make any health decisions on my behalf, upon the terms and conditions set
forth below. My health care representative accepts this appointment and agrees to act in my best interest as he or
she considers advisable. This health care power of attorney and appointment of health care agent and proxy may
be revoked by me at any time and is automatically revoked on my death. However, this power of attorney shall
not be affected by my present or future disability or incapacity.

This health care power of attorney and appointment of health care agent and proxy has the following terms and
conditions:

1. If I have signed a Living Will or Directive to Physicians, and it is still in effect, I direct that my health care
representative abide by the directions that I have set out in that document.

2. If at any time I should have an incurable injury, disease, or illness which has been certified as a terminal
condition by my attending physician and one additional physician, both of whom have personally examined me,
and such physicians have determined that there can be no recovery from such condition and my death is imminent,
and where the application of life prolonging procedures would serve only to artificially prolong the dying process,
then:

I direct my health care representative to assure that such procedures be withheld or withdrawn, and that I be
permitted to die naturally with only the administration of medication, the administration of nutrition and/or
hydration, or the performance of any medical procedure deemed necessary to provide me with comfort, care, or
to alleviate pain.

3. If at any time I should have been diagnosed as being in a persistent vegetative state which has been certified
as incurable by my attending physician and one additional physician, both of whom have personally examined
me, and such physicians have determined that there can be no recovery from such condition, and where the
application of life prolonging procedures would serve only to artificially prolong the dying process, then

I direct that my health care representative assure that such procedures be withheld or withdrawn, and that I be
permitted to die naturally with only the administration of medication, the administration of nutrition and/or
hydration, or the performance of any medical procedure deemed necessary to provide me with comfort, care, or
to alleviate pain.

**THE FOLLOWING INSTRUCTIONS (IN BOLDFACE TYPE) ONLY APPLY IF I HAVE SIGNED MY
NAME IN THIS SPACE:**

**However, if at any time I should have been diagnosed as being in a persistent vegetative state which has been
certified as incurable by my attending physician and one additional physician, both of whom have personally
examined me, and such physicians have determined that there can be no recovery from such condition, I also
direct that my health care representative have sole authority to order the withholding of any aid, including**

**the administration of nutrition, hydration, and any other medical procedure deemed necessary to provide
me with comfort, care, or to alleviate pain.**

4. If I am able to communicate in any manner, including even blinking my eyes, I direct that my health care
representative try and discuss with me the specifics of any proposed health care decision.

5. If I have any further terms or conditions, I state them here:

11

I intend for my attorney-in-fact under this Power of Attorney to be treated as I would be with
respect to my rights regarding the use and disclosure of my individually identifiable health
information or other medical records. This release authority applies to any information governed
by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d
and 45 CFR 160.164.

I have read the Notice that precedes this document. I understand the full importance of this
appointment. I am over 18 years of age and I am emotionally and mentally competent to make this
appointment of health care representative.

Dated _____, 20____

12

Signature of person granting health care power of attorney and appointing health care
representative

13

I, _____ (printed name), the first witness, and

14

I, _____ (printed name), the second witness,
sign my name to the foregoing power of attorney being first duly sworn and do declare to the
undersigned authority that the principal signs and executes this instrument as his/her power of
attorney and that he/she signs it willingly, or willingly directs another to sign for him/her, and
that I, in the presence and hearing of the principal, sign this power of attorney as witness to the
principal's signing and that to the best of my knowledge the principal is eighteen years of age or
older, of sound mind and under no constraint or undue influence. I am not related to the principal,
nor am I entitled to any portion of the principal's estate. I also do not provide health care services
to the principal and am not financially responsible for the principal's health care.

15

Signature of First Witness Address of First Witness

16

Signature of Second Witness Address of Second Witness

17

Notary Acknowledgement

State of _____

18

County of _____

19

On _____, 20____, _____ came before me
personally and under oath, stated that he/she is the person described in the above document and
he/she signed the above document in my presence. The witnesses _____

21

22

and _____ also came before me and attested to the above
statement and signed the document in my presence.

23

Notary Signature
Notary Public In and for the County of _____ State of _____

24

25

26

My commission expires: _____ Notary Seal

27

28

I accept my appointment as health care attorney-in-fact and health care representative.

29

Signature of person granted health care power of attorney and appointed as health care
representative

Health Care Power of Attorney and Appointment of Health Care Agent and Proxy

Notice to Adult Signing this Document: This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you. Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact **GENERALLY** will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so.

The authority of the attorney in fact to make health care decisions for you **GENERALLY** will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact **GENERALLY** will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

GENERALLY, you may designate any competent adult as the attorney in fact under this document. You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician. If you execute this document and create a valid Health Care Power of Attorney with it, it will revoke any prior, valid power of attorney for health care that you created, unless you indicate otherwise in this document. This document is not valid as a Health Care Power of Attorney unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

I, _____, residing at _____, City of _____, State of _____, appoint the following person as my attorney-in-fact for health care decisions, my health care agent, and confer upon this person my health care proxy. This person shall hereafter referred to as my "health care representative":

_____, residing at _____, City of _____, State of _____.

I grant my health care representative the maximum power under law to perform any acts on my behalf regarding health care matters that I could do personally under the laws of the State of _____, including specifically the power to make any health decisions on my behalf, upon the terms and conditions set forth below. My health care representative accepts this appointment and agrees to act in my best interest as he or she considers advisable. This health care power of attorney and appointment of health care agent and proxy may be revoked by me at any time and is automatically revoked on my death. However, this power of attorney shall not be affected by my present or future disability or incapacity.

This health care power of attorney and appointment of health care agent and proxy has the following terms and conditions:

1. If I have signed a Living Will or Directive to Physicians, and it is still in effect, I direct that my health care representative abide by the directions that I have set out in that document.

2. If at any time I should have an incurable injury, disease, or illness which has been certified as a terminal condition by my attending physician and one additional physician, both of whom have personally examined me, and such physicians have determined that there can be no recovery from such condition and my death is imminent, and where the application of life prolonging procedures would serve only to artificially prolong the dying process, then:

I direct my health care representative to assure that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the administration of nutrition and/or hydration, or the performance of any medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain.

3. If at any time I should have been diagnosed as being in a persistent vegetative state which has been certified as incurable by my attending physician and one additional physician, both of whom have personally examined me, and such physicians have determined that there can be no recovery from such condition, and where the application of life prolonging procedures would serve only to artificially prolong the dying process, then

I direct that my health care representative assure that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the administration of nutrition and/or hydration, or the performance of any medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain.

THE FOLLOWING INSTRUCTIONS (IN BOLDFACE TYPE) ONLY APPLY IF I HAVE SIGNED MY NAME IN THIS SPACE: _____

However, if at any time I should have been diagnosed as being in a persistent vegetative state which has been certified as incurable by my attending physician and one additional physician, both of whom have personally examined me, and such physicians have determined that there can be no recovery from such condition, I also direct that my health care representative have sole authority to order the withholding of any aid, including

the administration of nutrition, hydration, and any other medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain.

4. If I am able to communicate in any manner, including even blinking my eyes, I direct that my health care representative try and discuss with me the specifics of any proposed health care decision.

5. If I have any further terms or conditions, I state them here:

I have discussed my health care wishes with the person whom I have herein appointed as my health care representative, I am fully satisfied that the person who I have herein appointed as my health care representative will know my wishes with respect to my health care and I have full faith and confidence in their good judgement.

I further direct that my health care representative shall have full authority to do the following, should I lack the capacity to make such a decision myself, provided however, that this listing shall in no way limit the full authority that I give my health care representative to make health care decisions on my behalf:

- a. to give informed consent to any health care procedure;
- b. to sign any documents necessary to carry out or withhold any health care procedures on my behalf, including any waivers or releases of liabilities required by any health care provider;
- c. to give or withhold consent for any health care or treatment;
- d. to revoke or change any consent previously given or implied by law for any health care treatment;
- e. to arrange for or authorize my placement or removal from any health care facility or institution;
- f. to require that any procedures be discontinued, including the withholding of any medical treatment and/or aid, including the administration of nutrition, hydration, and any other medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain, subject to the conditions earlier provided in this document.
- g. to authorize the administration of pain-relieving drugs, even if they may shorten my life.

I desire that my wishes with respect to all health care matters be carried out through the authority that I have herein provided to my health care representative, despite any contrary wishes, beliefs, or opinions of any members of my family, relatives, or friends.

I have read the Notice that precedes this document. I understand the full importance of this appointment, and I am emotionally and mentally competent to make this appointment of health care representative.

I intend for my attorney-in-fact under this Power of Attorney to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

I have read the Notice that precedes this document. I understand the full importance of this appointment. I am over 18 years of age and I am emotionally and mentally competent to make this appointment of health care representative.

Dated _____, 20____

Signature of person granting health care power of attorney and appointing health care representative

Witness Attestation

I, _____ (printed name), the first witness, and

I, _____ (printed name), the second witness, sign my name to the foregoing power of attorney being first duly sworn and do declare to the undersigned authority that the principal signs and executes this instrument as his/her power of attorney and that he/she signs it willingly, or willingly directs another to sign for him/her, and that I, in the presence and hearing of the principal, sign this power of attorney as witness to the principal's signing and that to the best of my knowledge the principal is eighteen years of age or older, of sound mind and under no constraint or undue influence. I am not related to the principal, nor am I entitled to any portion of the principal's estate. I also do not provide health care services to the principal and am not financially responsible for the principal's health care.

Signature of First Witness Address of First Witness

Signature of Second Witness Address of Second Witness

Notary Acknowledgement

State of _____

County of _____

On _____, 20____, _____ came before me personally and, under oath, stated that he/she is the person described in the above document and he/she signed the above document in my presence. The witnesses _____

and _____ also came before me and attested to the above statement and signed the document in my presence.

Notary Signature

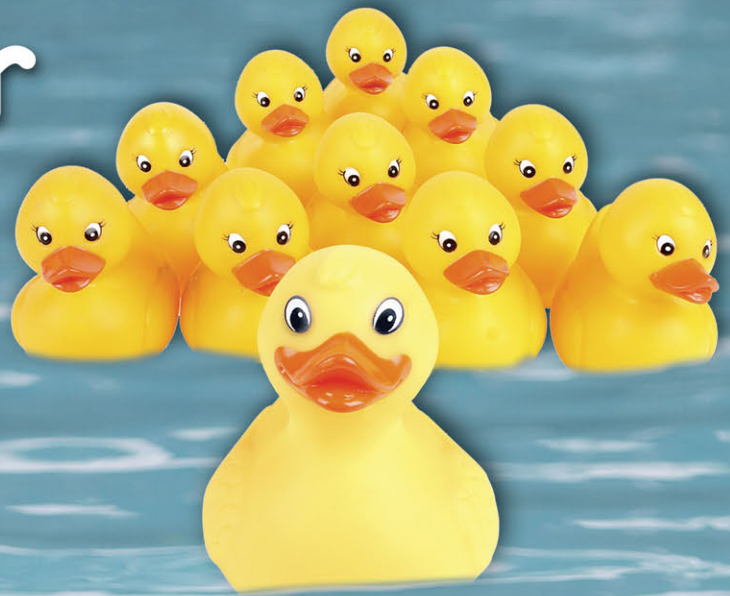
Notary Public In and for the County of _____ State of _____

My commission expires: _____ Notary Seal

I accept my appointment as health care attorney-in-fact and health care representative.

Signature of person granted health care power of attorney and appointed as health care representative

Got all your DUCKS in a row?



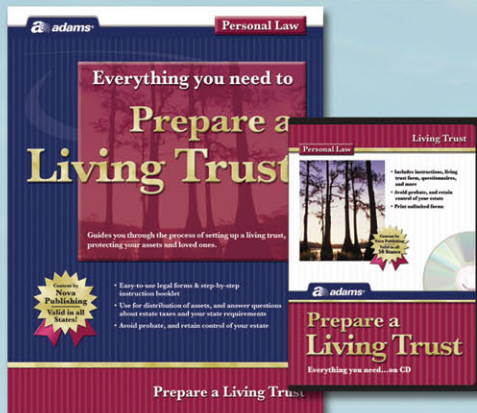
Protect your family
and your assets!



Last Will & Testament

Use for distribution of assets, as well as children's trusts and funeral arrangements, if desired.

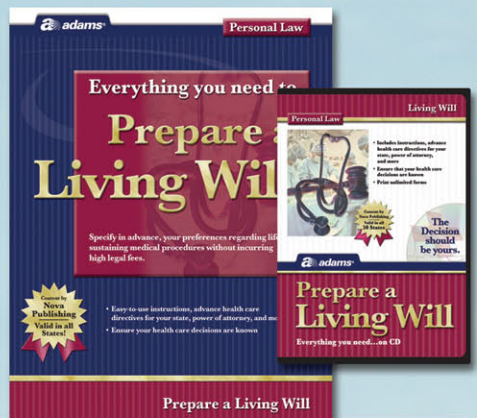
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Living Trusts

Avoid probate, and retain control of your estate. Use for distribution of assets, and answer questions about estate taxes and your state requirements.

Available on CD and in a kit



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Available on CD and in a kit

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