

# Health Care Power of Attorney

## 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 be 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.

Date \_\_\_\_\_

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

**Witness Attestation**

I, \_\_\_\_\_, the first witness, and I, \_\_\_\_\_, 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

\_\_\_\_\_  
Signature of Second Witness

\_\_\_\_\_  
Address of First Witness

\_\_\_\_\_  
Address of Second Witness

**Notary Acknowledgment**

State of \_\_\_\_\_ County of \_\_\_\_\_

On \_\_\_\_\_, \_\_\_\_\_ 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 attested to the above statement and signed the document in my presence.

\_\_\_\_\_  
Notary Public Signature

Notary Public In and for the County of \_\_\_\_\_ State of \_\_\_\_\_

My commission expires: \_\_\_\_\_ Seal

**Acceptance of Appointment as Attorney-in-Fact**

I accept my appointment as Attorney-in-Fact.

\_\_\_\_\_  
Signature of Attorney-in-Fact

\_\_\_\_\_  
Printed Name of Attorney-in-Fact

***California residents or persons intending that this document be valid in the State of California should use the following California Notary Acknowledgment form and the following California Witness Acknowledgments:***

**California Notary Acknowledgment**

State of California

County of \_\_\_\_\_ } S.S.

On \_\_\_\_\_, before me, \_\_\_\_\_

(name and title of notary), personally appeared \_\_\_\_\_, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct. WITNESS my hand and official seal.

\_\_\_\_\_  
Notary Signature

(Seal)

**California Witness Acknowledgment**

**Witness #1 Statement:** I declare under penalty of perjury under the laws of California that:

- (1) the individual who signed or acknowledged this health care power of attorney is personally known to me, or that the individual’s identity was proven to me by convincing evidence;
- (2) the individual signed or acknowledged this health care power of attorney in my presence;
- (3) the individual appears to be of sound mind and under no duress, fraud, or undue influence;
- (4) I am not a person appointed as an agent by this health care power of attorney; and
- (5) I am at least eighteen (18) years of age and I am not the individual’s health care provider, an employee of the individual’s health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, or an employee of an operator of a residential care facility for the elderly.

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Witness

**California Witness #2 Statement:** I declare under penalty of perjury under the laws of California that:

- (1) the individual who signed or acknowledged this health care power of attorney is personally known to me, or that the individual’s identity was proven to me by convincing evidence;
- (2) the individual signed or acknowledged this health care power of attorney in my presence;
- (3) the individual appears to be of sound mind and under no duress, fraud, or undue influence;
- (4) I am not a person appointed as an agent by health care power of attorney; and
- (5) I am not the individual’s health care provider, an employee of the individual’s health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly. I further declare under penalty of perjury under the laws of California that I am at least eighteen (18) years of age and I am not related to the individual executing this health care power of attorney by blood, marriage, or adoption, and, to the best of my knowledge, am not entitled to any part of the individual’s estate upon his or her death under a will now existing or by operation of law.

\_\_\_\_\_  
Second Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Second Witness

**Special Witness Requirement:** The following statement is required only if the person granting this health care power of attorney is a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis.

The patient advocate or ombudsman must sign the following statement:

**Statement of Patient Advocate or Ombudsman:** I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

\_\_\_\_\_  
Special Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Title of Special Witness