Durable Power of Attorney for Health Care Decisions

I hereby create a durable power of attorney for health care decisions by appointing the person designated below to make health care decisions for me. This power shall become effective at the time I become incapable of giving informed consent for health care decisions or as specified below. This power of attorney shall not be affected by my subsequent disability or incapacity.

If I become incapable of giving informed consent for health care decisions and protective proceedings have not commenced regarding the guardianship of my person, I hereby grant to my agent, subject to any limitations stated herein, full power and authority to make health care decisions for me including the right to consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition, and to authorize release of medical information. This authority is subject to the special provisions and limitations set out as follows:

The agent shall be prohibited from authorizing consent for the items marked below:

_____

_____

_____

Additional statement of desires, special provisions, limitations, organ donation, autopsy and disposition of my body:

_____

_____

_____

I, _____ _____
Print legal name Date of birth

do hereby designate and appoint _____, residing at _____

_____ as my agent to make health care decisions for me

as authorized in this document. Telephone number:_____

If protective proceedings are commenced pursuant to my incapability, I hereby nominate to the court, pursuant to subsection (b) of K.S.A. 58-612, and amendments thereto or applicable statutes, the above named agent (or alternate) to be the conservator or guardian.

If the person designated in paragraph 3 as my agent is not available and willing to make a health care decision for me, then I designate the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First alternate agent

_____
Name

_____
Address

_____
City/State/Zip

_____
Telephone number

B. Second alternate agent

_____
Name

_____
Address

_____
City/State/Zip

_____
Telephone number

I understand that this durable power of attorney for health care decisions will exist from the date I execute this document until I revoke this power.

Patient Label

I revoke any prior durable power of attorney for health care decisions.

I sign my name to the Durable Power of Attorney for Health Care Decisions on_____
Month/ Day / Year

_____ _____
Print legal name Signature

This document must be (1) Witnessed by two witnesses at least 18 years of age who are not the agent; not related to you by blood, marriage or adoption; not entitled to any portion of your estate; and not directly financially responsible for your health care; OR, (2) acknowledged by a notary public.

I did not sign the Principal's signature above for or at the direction of the Principal. I am not related to the Principal by blood or marriage, entitled to any portion of the estate under any will of Principal or codicil thereto, or directly financially responsible for the Principal's medical care.

_____ _____
Witness Witness

_____ _____
Address Address

_____ _____
City/State/Zip City/State/Zip

or

State of _____ County of _____

This instrument was acknowledged before me on _____(date)

by _____ (name of person)

_____ (Seal, if any)
Signature of notary public

My appointment expires: _____

If the principal is physically unable to sign the power of attorney but otherwise competent and conscious, the power of attorney may be signed by an adult designee of the principal in the presence of the principal and at the specific direction of the principal expressed in the presence of a notary public. The designee shall sign the principal's name to the power of attorney in the presence of a notary public, following which the document shall be acknowledged in the manner prescribed by K.S.A. 53-509 et. seq., and amendments thereto, to the same extent and effect as if physically signed by the principal.

K.S.A. 53-509, regarding acknowledgments, has been amended to add another form: (f) For Power of attorney in a representative capacity: State of Kansas, County of _____, ss

This instrument was acknowledged before me on _____(date)

by_____ (name of person) as power of attorney of

_____(name of party on behalf of whom instrument was executed).

_____ My appointment expires: _____
Signature of notary public

(Seal, if any)

Patient Label