When Recorded mail to:

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DURABLE POWER-OF-ATTORNEY

HEALTH CARE

Name of Principal _____
Principal's Address _____

Name of Agent _____
Address of Agent _____

1. I, as principal (the "Principal") intend to create by this instrument a Durable Power of Attorney for health care and do hereby appoint my Agent ("Agent") to act for me and in my name and exercise the powers set forth below in matters involving my health and medical care. Accordingly, my Agent is authorized as follows:

2. Subject to any limitations in this document, I hereby grant to my Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise make known to my Agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life prolonging care, treatment, services, psychiatric services and other procedures.

3. I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care, including hospitals, to release to my Agent all information contained in my medical records which my Agent may request. I hereby waive all privileges attached to physician-patient relationship and to any communication, verbal or written, arising out of such a relationship. My Agent is authorized to request, receive and review any information, verbal or written, pertaining to my physical or mental health, including medical and hospital records, and to execute any releases, waivers or other documents that may be required in order to obtain such information, and to disclose such information to such persons, organizations and health care providers as my Agent shall deem appropriate.

4. My Agent is authorized to employ and discharge health care providers including physicians, psychiatrists, dentists, nurses, and therapists as my Agent shall deem appropriate for my physical, mental and emotional well-being. My Agent is also authorized to pay reasonable fees and expenses for such services contracted.

5. My Agent is authorized to apply for my admission to a medical, nursing, residential, mental health or other similar facility, execute any consent or admission forms required by such facility and enter into agreements for my care at such facility or elsewhere during my lifetime or for such lesser periods of time as my Agent may designate.

6. My Agent is authorized to arrange for and consent to medical, therapeutical and surgical procedures for me including the administration of drugs. The power to make health care decisions for me shall include the power to give consent, refuse, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

7. I reserve unto myself the right to revoke the authority granted to my Agent hereunder to make health care decisions for me by notifying the treating physician, hospital, or other health care provider orally or in writing.

8. Notwithstanding any provision herein to the contrary, I retain the right to make medical and other health care decisions for myself so long as I am able to give informed consent with respect to a particular decision. In addition, no treatment may be given to me over my objection, and health care necessary to keep me alive may not be stopped if I object.

9. If at any time I should have a terminal condition and my attending physician and another physician, independently of each other, have determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care and alleviate pain.

   For purposes of this declaration, life-prolonging procedure shall mean any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. "Life-prolonging procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort, care or alleviate pain.

10. If I have been in an irreversible coma with no reasonable possibility of my ever regaining consciousness, I direct that all procedures used to provide me with nourishment and water (including, for instance, through intravenous feeding and through endotracheal or nasogastric tube means) not be instituted, or if already instituted, withdrawn.

11. This power of attorney shall not be affected by subsequent disability or incapacity of the principal. Not withstanding any provision herein to the contrary, my Agent shall take no action under this instrument unless I am deemed to be disabled or incapacitated as defined herein. My incapacity shall be deemed to exist when so certified in writing by two licensed physicians not related by blood or marriage to either me or to my Agent. The said certificate shall state that I am incapable of caring for myself and that I am physically and mentally incapable of managing my financial affairs. The certificate of the physicians described above shall be attached to the original of this instrument and if this instrument is filed or recorded among public records, then such certificate shall also be similarly filed or recorded if permitted by applicable law.

12. My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this instrument.

13. To the extent permitted by law, I herewith nominate, constitute and appoint my Agent to serve as my guardian, conservator and/or in any similar representative capacity; and, if I am not permitted by law to so nominate, constitute and appoint, then I request any court of competent jurisdiction which may be petitioned by any person to appoint a guardian, conservator or similar representative for me to give due consideration to my request.

14. In the event my Agent is unable or unwilling to serve or to continue to serve, then I appoint:

Successor Agent _____

Address _____

_____

City/County/State/Zip

to serve as substitute or successor agent who shall have all the title, powers and discretion herein given my Agent.

15. My Agent is authorized to make photocopies of this instrument as frequently as necessary. All photocopies shall have the same force and effect as the original.

16. If any provision of this instrument or its application to any person or circumstances is held invalid, such invalidity shall not affect other provision or applications of this instrument which can be given effect without the invalid provision or application, and to this end the provisions of this instrument are severable.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.

A. General Grant of Power and Authority. Subject to any limitations in this Directive, my agent has the power and authority to do all of the following: (1) Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records; (2) Execute on my behalf any releases or other documents that may be required in order to obtain this information; (3) Consent to the disclosure of this information; and (4) Consent to the donation of any of my organs for medical purposes.

B. HIPAA Release Authority. My agent shall 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 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

The undersigned Agent acknowledges and accepts appointment as Agent under this instrument.

IN WITNESS WHEREOF, I/we have hereunto set our hand and seal at _____, on this _____ day of _____, 20_____.

_____ _____

Principal Agent

I, _____, the principal, sign my name to this power of attorney this _____ day of _____ and, being first duly sworn, do declare to the undersigned authority that I sign and execute this instrument as my power of attorney and that I sign it willingly, or willingly direct another to sign for me, that I execute it as my free and voluntary act for the purposes expressed in the power of attorney and that I am eighteen years of age or older, of sound mind and under no constraint or undue influence.

_____

Principal

I, _____, the 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.

_____

Witness

State of Arizona
County of _____

Subscribed, sworn to and acknowledged before me by _____, the principal, and subscribed and sworn to before me by _____, witness, this _____ day of _____.

_____
Notary Public

SEAL