DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This is an important legal this is an important legal document which is authorized by the Uniform Durable Power of Attorney Act, Section 551D, 1999 Hawaii Revised Statutes. Before executing this document, you should know these important facts: this document gives the person you designate as your agent (the attorney-in-fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known. Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent (1) authorizes anything that is illegal, (2) acts contrary to your known desires, or (3) where your desires are not known, does anything that is clearly contrary to your best interests.

The powers given by this document will exist for an indefinite period of time unless you limit their duration in this document. You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation. Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document. Unless you otherwise specify in this document, this document gives your agent the power after you die to (1) authorize an autopsy, (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and (3) direct the disposition of your remains.

This document revokes any prior durable power of attorney for health care.

You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You may also want to give your doctor an executed copy of this document.

1. <u>DESIGNATION OF HEALTH CARE AGENT</u>.

I, _____ (Insert your name and address)

do hereby designate and appoint

_____ (Insert name, address, and telephone number of designee)

as my agent to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

By this document I intend to create a durable power of attorney for health care under the Uniform Durable Power of Attorney Act, Section 551D, 1999 Hawaii Revised Statutes. **This power of attorney shall not be affected by my subsequent incapacity.**

3. GENERAL STATEMENT OF AUTHORITY GRANTED.

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 those 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 made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph.)

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.

(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

(a) Statement of desires concerning life-prolonging care, treatment, services, and procedures:

_____
_____
_____
_____

(b) Additional statement of desires, special provisions, and limitations:

_____
_____
_____
_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

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

Subject to any limitations in this document, my agent has the power and authority to do all of the following:

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.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") above.)

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES.

Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

7. AUTOPSY; ANATOMICAL GIFTS; DISPOSITION OF REMAINS.

Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Authorize an autopsy;

(b) Make a disposition of a part or parts of my body under the Uniform Anatomical Gift Act; and

(c) Direct the disposition of my remains.

(If you want to limit the authority of your agent to consent to an autopsy, make an anatomical gift, or direct the disposition of your remains, you must state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") above.)

8. DURATION.

(Unless you specify otherwise in the space below, this power of attorney will exist for an indefinite period of time.)

This durable power of attorney for health care expires on _____
(Fill in this space ONLY if you want to limit the duration of this power of attorney.)

9. DESIGNATION OF ALTERNATE AGENTS.

(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, these persons to serve in the order listed below:

A. First Alternate Agent

_____

(Insert name, address, and telephone number of first alternate agent)

B. Second Alternate Agent

_____

(Insert name, address, and telephone number of second alternate agent)

10. NOMINATION OF CONSERVATOR OF PERSON.

(A conservator of the person may be appointed for you if a court decides that one should be appointed. The conservator is responsible for your physical care, which under some circumstances includes making health care decisions for you. You are not required to nominate a conservator but you may do so. The court will appoint the person you nominate unless that would be contrary to your best interests. You may, but are not required to, nominate as your conservator the same person you named in paragraph 1 as your health care agent. You can nominate an individual as your conservator by completing the space below.)

If a conservator of the person is to be appointed for me, I nominate the following individual to serve as conservator of the person:

_____

(Insert name and address of person nominated as conservator of the person)

11. PRIOR DESIGNATIONS REVOKED.

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

_____

STATE OF _____)
)ss
COUNTY OF _____)

OATH AND VERIFICATION

On this date: _____, before us, the undersigned Witness 1 and Witness 2, personally appeared the above Principal, respectively, known to us or satisfactorily proven to be the person whose name is subscribed to this instrument. We as Witnesses to this Power of Attorney declare that neither Witness 1 or Witness 2 is the above appointed Attorney-In-Fact, a health-care provider, or an employee of a health-care provider or facility. At least one of the undersigned Witnesses are neither related to the principal by blood, marriage, or adoption, nor entitled to any portion of the estate of the principal upon the principal's death under any will or codicil thereto of the principal existing at the time of execution of the power of attorney for health care or by operation of law then existing.

The Principal, being duly sworn, did hereby declare that Principal signed and executed this instrument as Principal's Durable Power of Attorney appointing the above named Attorney-In-Fact and had signed willingly and executed it as Principal's free and voluntary act for the purposes therein expressed, and that each of the Witnesses, in the presence of the Principal, Notary and each other signed this Power of Attorney as Witnesses; and that to the best of our knowledge, the Principal was at the time an adult, of sound mind and under no constraint or undue influence.

This instrument was subscribed, sworn and acknowledged before us.

_____	_____
Witness 1	Witness 2
_____	_____
Address	Address
_____	_____
Principal	Attorney-In-Fact

On this _____ of _____, 20_____, personally appeared before me, _____, personally known to me or proved to me on the basis of satisfactory evidence to be the above named Principal whose name is subscribed to this instrument, and acknowledged that he/she executed the same in front of myself and the above

signed Witnesses. At the time of execution the Principal was at the time an adult, of sound mind and under no constraint or undue influence.

Notary Public_____

(seal)