MANDATE OR POWER OF ATTORNEY FOR HEALTH CARE

APPOINTMENT OF MANDATARY (AGENT) FOR MEDICAL DECISIONS.

I, _____, (print full name) being of sound mind, do hereby designate _____ (print full name) as my agent with full power and authority to make health care decisions for me including, but not limited to, a Declaration Concerning Life-Sustaining Procedures in the event I am unable to or choose not to make these decisions for myself. This Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity or other condition that makes an express revocation of my agent impossible or impractical unless I express wishes to the contrary in the "Duration" section below. I also grant my agent the authority to qualify me for all government entitlements including, but not limited to, Medicaid, Medicare, and Supplemental Social Security.

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 3 ("Statement of Desires, Special Provisions, and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph.)

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.)

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) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(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 3 ("Statement of Desires, Special Provisions, and Limitations") above.)

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.

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.

(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 3 ("Statement of Desires, Special Provisions, and Limitations") above.)

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.)

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)

_____

SIGNATURE

_____

PRINT NAME

_____

CITY, PARISH OF RESIDENCE

_____

STATE OF RESIDENCE

The declarant has been personally known to me and I believe him or her to be of sound mind.

_____

WITNESS 1 SIGNATURE

WITNESS 1 PRINT NAME

_____

_____

WITNESS 2 SIGNATURE

WITNESS 2 PRINT NAME

_____

Notarization of this form is optional.

Sworn and subscribed before me, this _____ day of _____, 20_____.

_____

Notary Public

#_____

My commission expires _____