STATUTORY FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(Rhode Island General Laws § 23-4.10-2)

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen (18) years of age and a resident of the state for this document to be legally valid and binding.

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 limitation 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.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death.

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.

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) DESIGNATION OF HEALTH CARE AGENT

I, _____ *(insert your name and address)* do hereby designate and appoint:

_____ *(insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider, (2) a nonrelative employee of your treating health care provider, (3) an operator of a community care facility, or (4) a nonrelative employee of an operator of a community care facility.)* as my attorney in fact (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.

(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 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 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 regarding health care decisions:

(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.)

If you wish to make a gift of any bodily organ you may do so pursuant to the Uniform Anatomical Gift Act.

(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) 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 (4) ("Statement of desires, special provisions, and limitations") above.)

(5) 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.

(6) DURATION

(Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.)

This durable power of attorney for health care expires on _____

(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

(8) 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, such 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.)

_____

_____

_____

(9) PRIOR DESIGNATIONS REVOKED

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

DATE AND SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on

Date: _____

City: _____

State: _____

Signature: _____

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY TWO (2) QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR

ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

STATEMENT OF WITNESSES

(This document must be witnessed by two (2) qualified adult witnesses. None of the following may be used as a witness:

(1) A person you designate as your agent or alternate agent,

(2) A health care provider,

(3) An employee of a health care provider,

(4) The operator of a community care facility,

(5) An employee of an operator of a community care facility.

At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

Signature: _____

Residence Address: _____

Print Name: _____

Date: _____

Signature: _____

Residence Address: _____

Print Name: _____

Date: _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Print Name: _____

Signature: _____

Print Name: _____