

DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

(South Dakota Codified Laws Chapter 59-7)

(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. This power of attorney shall not be affected by my disability. I expressly reserve the right to revoke this power of attorney at any time.

(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.

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.

(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.)

(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) 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.)

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this Durable Power of Attorney for Health Care in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, that neither of us is:

A person appointed as an attorney-in-fact by this document;

The principal's attending physician or mental health service provider or a relative of the physician or provider;

The owner or operator or a relative of an owner or operator of a facility in which the principal is a patient or resident; or

A person related to the principal by blood, marriage, or adoption.

Witnessed by:

(Signature of Witness/Date)

(Printed Name of Witness)

(Signature of Witness/Date)

(Printed Name of Witness)

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about health care treatment for the principal. I understand that I have a duty to act in a manner that is consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about health care treatment only while the principal is incapable. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner if the principal is capable.

(Signature of Attorney-in-fact/Date)

(Printed name)

(Signature of Alternative Attorney-in-fact/Date)

(Printed name)