

NOTICE TO PERSON MAKING THIS DOCUMENT

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT. BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT.

YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE.

IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR DOCUMENT OF GIFT THAT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.

**IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON
FILE WITH YOUR PHYSICIAN.**

POWER OF ATTORNEY:
CARE AND CUSTODY OF CHILD OR CHILDREN

KNOW ALL MEN BY THESE PRESENTS: That the undersigned,
_____, parent(s) of the child(ren) identified below,
residing at _____ hereby make, constitute and
appoint _____ (if more than one attorney-in-fact is appointed, add "Jointly,"
"either of them" or "any one of them" to indicate how they must act) as the true and lawful Attorney(s)-in-
Fact of the undersigned, to act in name, place and stead of the undersigned, to do and execute
all or any of the following acts, deeds and things with respect to the care and custody of the
following child(ren):

- (a) To participate in decisions regarding the child(ren)'s education including attending conferences with the child(ren)'s teachers or any other educational authorities, granting permission for the child(ren)'s participation in school trips and other activities, and making any other decisions and executing any documents pertinent to their education.

- (b) To grant permission and consent to the child(ren) participating in any activity sponsored by any group, association or organization which activity the Attorney(s)-in-Fact may deem appropriate.

- (c) To make health care decisions on behalf of the child(ren), including making decisions regarding the child(ren)'s medical or dental care, whether routine or emergency in nature, including admissions to hospitals or other institutions; to consent to, to refuse to consent to, or to withdraw consent to the provision of any care, tests, treatment, surgery, service or procedure to maintain, diagnose or treat a physical or mental condition, as well as the right to sign such medical forms as may be necessary to carry out such decisions; to talk with health care personnel who may be treating the child(ren) and to examine the child(ren)'s medical records and to consent to the disclosure of such records in circumstances the Attorney(s)-in-

Fact may deem appropriate; to file claims for medical insurance and to obtain information from any insurance company with respect to any policy of health or medical insurance under which the child(ren) may be insured; provided however, that the Attorney(s)-in-Fact shall not be required to execute any documents which would involve incurring any personal liability for any such treatment and care, and the undersigned affirms that the undersigned will be responsible for payment for any such care or treatment consented to by the Attorney(s)-in-Fact of the undersigned which is not covered by insurance.

(d) To generally do and perform all matters and things, to execute all other instruments of every kind which may be necessary or proper to effectuate all powers hereinabove specifically granted, or any other matter or thing appertaining to the child(ren) of the undersigned, with the same full powers, and to all intents and purposes, with the same validity as the undersigned could, if personally present; and hereby ratifying and confirming whatsoever said Attorney(s)-in-Fact of the undersigned shall and may do, by virtue hereto.

(e) SPECIFICALLY EXCLUDED FROM THE AUTHORITY AND POWERS GRANTED HEREIN IS THE AUTHORITY OR POWER TO CONSENT TO THE MARRIAGE OR ADOPTION OF THE CHILD(REN) NAMED HEREIN.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY CHILD'S 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 child's 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 child's 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 child's 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 my child, 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 child's 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 child's health care providers to restrict access to or disclosure of my child's 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 child's health care provider.

The powers herein granted to said Attorney(s)-in-Fact of the undersigned shall be exercisable by any one of them or all of them at any time and from time to time from _____ until _____, not to exceed one year.

This Power of Attorney shall remain in full force and effect until the date stated above, and any party dealing with the Attorney (s)-in-fact during such time shall be fully protected and is hereby discharged, released and indemnified from so doing in respect of any matter relating hereto unless such particular party shall have received prior notice in writing of the revocation of this Power of Attorney.

We further understand that this temporary power of attorney (delegation) of our parental powers does not relieve us of the primary responsibility of our child.

Signed this _____ day of _____, 20_____

(Your Signature)

(Your Signature)

By signing as a witness, I am acknowledging the signature of the principal who signed in my presence and the presence of the other witness, and the fact that he or she has stated that this power of attorney reflects his or her wishes and is being executed voluntarily. I believe him or her to be of sound mind and capable of creating this power of attorney. I am not related to him or her by blood, marriage or adoption, and, to the best of my knowledge, I am not entitled to any portion of his or her estate under his or her will.

Printed Name: _____

Address: _____

Signature: _____

Date: _____

Printed Name: _____

Address: _____

Signature: _____

Date: _____

State of Wisconsin

County of _____

This document was acknowledged before me on _____

(date) by _____ (name of principal).

(Signature of Notarial Officer)

(Seal, if any)

(Title)

My commission is permanent or expires:
