STATE OF ARIZONA
DURABLE HEALTH CARE POWER OF ATTORNEY
Instructions and Form

GENERAL INSTRUCTIONS: Use this Durable Health Care Power of Attorney form if you want to select a person to make future health care decisions for you so that if you become too ill or cannot make those decisions for yourself the person you choose and trust can make medical decisions for you. Talk to your family, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson and a lawyer before you sign this form.

Be sure you understand the importance of this document. If you decide this is the form you want to use, complete the form. **Do not sign this form until** your witness or a Notary Public is present to witness the signing. There are further instructions for you about signing this form on page three.

1. Information about me: (I am called the "Principal")

My Name: _____ My Age: _____
My Address: _____ My Date of Birth: _____
_____ My Telephone: _____

2. Selection of my health care representative and alternate: (Also called an "agent" or "surrogate")

I choose the following person to act as my representative to make health care decisions for me:

Name: _____ Home Telephone: _____
Street Address: _____ Work Telephone: _____
City, State, Zip: _____ Cell Telephone: _____

I choose the following person to act as an alternate representative to make health care decisions for me if my first representative is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Telephone: _____
Street Address: _____ Work Telephone: _____
City, State, Zip: _____ Cell Telephone: _____

3. What I AUTHORIZE if I am unable to make medical care decisions for myself:

I authorize my health care representative to make health care decisions for me when I cannot make or communicate my own health care decisions due to mental or physical illness, injury, disability, or incapacity. I want my representative to make all such decisions for me except those decisions that I have expressly stated in Part 4 below that I do not authorize him/her to make. If I am able to communicate in any manner, my representative should discuss my health care options with me. My representative should explain to me any choices he or she made if I am able to understand. This appointment is effective unless and until it is revoked by me or by an order of a court.

The types of health care decisions I authorize to be made on my behalf include but are not limited to the following:

- To consent or to refuse medical care, including diagnostic, surgical, or therapeutic procedures;
- To authorize the physicians, nurses, therapists, and other health care providers of his/her choice to provide care for me, and to obligate my resources or my estate to pay reasonable compensation for these services;
- To approve or deny my admittance to health care institutions, nursing homes, assisted living facilities, or other facilities or programs. By signing this form I understand that I allow my representative to make decisions about my mental health care except that generally speaking he or she cannot have me admitted to a structured treatment setting with 24-hour-a-day supervision and an intensive treatment program – called a "level one" behavioral health facility – using just this form;

- To have access to and control over my medical records and to have the authority to discuss those records with health care providers.

4. DECISIONS I EXPRESSLY DO NOT AUTHORIZE my Representative to make for me:

I do not want my representative to make the following health care decisions for me (describe or write in "not applicable"):

_____
_____
_____
_____
_____

5. My specific desires about autopsy:

NOTE: Under Arizona law, an autopsy is not required unless the county medical examiner, the county attorney, or a superior court judge orders it to be performed. See the General Information document for more information about this topic. Initial or put a check mark by one of the following choices.

_____ Upon my death I DO NOT consent to (want) an autopsy.
_____ Upon my death I DO consent to (want) an autopsy.
_____ My representative may give or refuse consent for an autopsy.

6. My specific desires about organ donation: ("anatomical gift")

NOTE: Under Arizona law, you may donate all or part of your body. If you do not make a choice, your representative or family can make the decision when you die. You may indicate which organs or tissues you want to donate and where you want them donated. Initial or put a check mark by A or B below. If you select B, continue with your choices.

_____ **A.** I DO NOT WANT to make an organ or tissue donation, and I do not want this donation authorized on my behalf by my representative or my family.
_____ **B.** I DO WANT to make an organ or tissue donation when I die. Here are my directions:

1. What organs/tissues I choose to donate: (Select a or b below)
_____**a.** Any needed organ or parts.
_____**b.** These parts or organs:
1.) _____
2.) _____
3.) _____

2. What purposes I donate organs/tissues for: (Select a, b, or c below)
_____**a.** Any legally authorized purpose (transplantation, therapy, medical and dental evaluation and research, and/or advancement of medical and dental science).
_____**b.** Transplant or therapeutic purposes only.
_____**c.** Other: _____

3. What organization or person I want my parts or organs to go to:
_____ **a.** I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution: (Name) _____
_____

_____ **b.** I would like my tissues or organs to go to the following individual or institution: (Name) _____
_____ **c.** I authorize my representative to make this decision.

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7. About a Living Will:

NOTE: If you have a Living Will and a Durable Health Care Power of Attorney, **you must attach** the Living Will to this form. A Living Will form is available on the Attorney General (AG) web site. Initial or put a check mark by box A or B.

_____ **A.** I have SIGNED AND ATTACHED a completed Living Will in addition to this Durable Health Care Power of Attorney to state decisions I have made about end of life health care if I am unable to communicate or make my own decisions at that time.

_____ **B.** I have NOT SIGNED a Living Will.

8. About a Prehospital Medical Care Directive or Do Not Resuscitate Directive:

NOTE: A form for the Prehospital Medical Care Directive or Do Not Resuscitate Directive is available on the AG web site. Initial or put a check mark by box A or B.

_____ **A.** I and my doctor or health care provider HAVE SIGNED a Prehospital Medical Care Directive or Do Not Resuscitate Directive on paper with ORANGE background in the event that 911 or Emergency Medical Technicians or hospital emergency personnel are called and my heart or breathing has stopped.

_____ **B.** I have NOT SIGNED a Prehospital Medical Care Directive or Do Not Resuscitate Directive.

SIGNATURE OR VERIFICATION

I intend for my agent to 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 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

A. I am signing this Durable Health Care Power of Attorney as follows:

My Signature: _____ Date: _____

B. I am physically unable to sign this document, so a witness is verifying my desires as follows:

Witness Verification: I believe that this Durable Health Care Power of Attorney accurately expresses the wishes communicated to me by the principal of this document. He/she intends to adopt this Durable Health Care Power of Attorney at this time. He/she is physically unable to sign or mark this document at this time, and I verify that he/she directly indicated to me that the Durable Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Health Care Power of Attorney at this time.

Witness Name (printed): _____
Signature: _____ Date: _____

SIGNATURE OF WITNESS OR NOTARY PUBLIC:

NOTE**:** At least one adult witness OR a Notary Public must witness the signing of this document and then sign it. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this form is signed.

A. Witness: I certify that I witnessed the signing of this document by the Principal. The person who signed this Durable Health Care Power of Attorney appeared to be of sound mind and under no pressure to make specific choices or sign the document. I understand the requirements of being a witness and I confirm the following:

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- I am not currently designated to make medical decisions for this person.
- I am not directly involved in administering health care to this person.
- I am not entitled to any portion of this person's estate upon his or her death under a will or by operation of law.
- I am not related to this person by blood, marriage, or adoption.

Witness Name (printed): _____
Signature: _____ Date: _____
Address: _____

Notary Public (NOTE: If a witness signs your form, you DO NOT need a notary to sign):

STATE OF ARIZONA) ss
COUNTY OF _____)

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Durable Health Care Power of Attorney has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to the person signing above by blood, marriage or adoption, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing health care to the person signing. I am not entitled to any part of his/her estate under a will now existing or by operation of law. In the event the person acknowledging this Durable Health Care Power of Attorney is physically unable to sign or mark this document, I verify that he/she directly indicated to me that this Durable Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Health Care Power of Attorney at this time.

WITNESS MY HAND AND SEAL this ___ day of _____, 20___.
Notary Public _____ My Commission Expires: _____

OPTIONAL:
STATEMENT THAT YOU HAVE DISCUSSED YOUR HEALTH CARE CHOICES FOR THE FUTURE WITH YOUR PHYSICIAN

NOTE: Before deciding what health care you want for yourself, you may wish to ask your physician questions regarding treatment alternatives. This statement from your physician is not required by Arizona law. If you do speak with your physician, it is a good idea to have him or her complete this section. Ask your doctor to keep a copy of this form with your medical records.

On this date I reviewed this document with the Principal and discussed any questions regarding the probable medical consequences of the treatment choices provided above. I agree to comply with the provisions of this directive, and I will comply with the health care decisions made by the representative unless a decision violates my conscience. In such case I will promptly disclose my unwillingness to comply and will transfer or try to transfer patient care to another provider who is willing to act in accordance with the representative's direction.

Doctor Name (printed): _____

Signature: _____ Date: _____

Address: _____
