Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

RUSH UNIVERSITY MEDICAL CENTER

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Adv Directive-P
Durable Power of Attorney

IDN13150042

NOTICE: READ INFORMATION ON REVERSE SIDE BEFORE COMPLETING THIS FORM

POWER OF ATTORNEY made this _____ day of _____ 20 _____

1. I, the undersigned, hereby appoint (insert name and address of agent) _____

_____

as agent to act for me and in my name to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy and direct the disposition of my remains. (Neither the attending physician nor any other health care provider may act as your agent.)

2. The powers granted above shall be subject to the following rules or limitations (if none, leave blank):

_____

_____

(The subject of life-sustaining treatment is of particular importance. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. If you agree with one of these statements, you may initial that statement; but do not initial more than one.)

____ (I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the (burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and (the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

____ (I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a coma which my (attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when (I have suffered irreversible coma, I want life-sustaining treatment to be withheld or discontinued.

____ (I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the (cost of the procedures.

3. This power of attorney shall become effective on _____ .
4. This power of attorney shall terminate on _____ .
5. If any agent named by me shall die, become legally disabled, resign, refuse to act or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent:

_____

_____

6. If a guardian of my person is to be appointed, I nominate the following to serve as such guardian (if same as agent, leave blank):

_____

7. I am fully informed as to all the contents of this form and understand the full import of this grant of power to my agent.

Signed _____
Principal

The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence.

_____ Residing at _____
Witness

(You may, but are not required to, request your agent and successor agents to provide specimen signature below. If you include specimen signature in this Power of Attorney, you must complete the certification opposite the signatures of the agents.)

Specimen signatures of agent (and successors)

I certify that the signature of my agent (and successors) are correct.

_____ _____
(agent) (principal)

_____ _____
(successor agent) (principal)

_____ _____
(successor agent) (principal)

NOTICE: READ THE INFORMATION BELOW ABOUT THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE BEFORE COMPLETING THE REVERSE SIDE OF THIS FORM.

1. The Purpose of the Durable Power of Attorney For Health Care: The purpose of this power of attorney is to give the person you designate (in the form this person is referred to as your "agent") broad powers to make health care decisions for you (in the form you are referred to as the "principal"), including power to require, consent to or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit you to or discharge you from any hospital, home or other institution. This form does not impose a duty on your agent to exercise granted powers; but when a power is exercised your agent will have to use due care to care for your benefit and in accordance with this form. A court can take away the powers of your agent if it finds the agent is not acting properly. You may name successor agents under this form but not co-agents, and no health care provider may be named. Unless you expressly limit the duration of this power in the manner provided below, until you revoke this power or a court acting on your behalf terminates it, your agent may exercise the powers given here throughout your lifetime, even after you become disabled. The powers you give your agent, your right to revoke these powers and the penalties for violating the law are explained more fully in the Illinois "Powers of Attorney for Health Care Law" (Ch. 110-1/2, Sections 804-1 *et seq.*). That law expressly permits the use of any different form of power of attorney you may desire. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

2. Grant of Power Is Intended To Be As Broad As Possible: The grant of power found in paragraph 1 on the reverse side of this form is intended to be as broad as possible so that your agent will have authority to make any decision you could make to obtain or terminate any type of health care, including withdrawal of food and water and other life-sustaining measures, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to make an anatomical gift, authorize autopsy or dispose of remains, you may do so in paragraph 2 on the reverse side of this form.

3. Amending or Revoking the Power of Attorney: This Power of Attorney may be amended or revoked by you at any time and in any manner while you have the capacity to do so. Absent amendment or revocation, the authority granted in this Power of Attorney will become effective at the time this Power is signed and will continue until your death, and beyond if anatomical gift, autopsy or disposition of remains is authorized, unless a limitation on the beginning date or duration is made by you (see paragraphs 3 and 4 on the reverse side of this form.

4. Appointment of Successor Agents: If you wish to name successor agents, insert the names and addresses of such successors in paragraph 5 on the reverse side of this form.

5. Naming a Guardian of Your Person: If you wish to name a guardian of your person in the event a court decides that one should be appointed, you may, but are not required to do so, by inserting the name of such guardian in paragraph 6 on the reverse side of this form. The court will appoint the person nominated by you if the court finds that such appointment will serve your best interests and welfare. You may, but are not required to, nominate as your guardian the same person named in the form as your agent.