DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

I, (print your name)_____designate and appoint:

Name (print):_____
Address:_____
Telephone Number:_____

to be my agent for health care decisions and pursuant to the language stated below, on behalf to:

(1) Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical condition, and to make decisions about organ donation, autopsy and disposition of the body;
(2) Make all necessary arrangements at any hospitals, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care as the agent deem necessary for my physical and emotional well-being; and
(3) Request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute any release of other documents that may be required in order to obtain such information.
(4) In exercising the grant of authority set forth above my agent for health care shall:
(Here may be inserted any special instructions or statement of the principal's desired to be followed by the agent in exercising the authority granted.)

LIMITATIONS OF AUTHORITY

(1) The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for health care decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.
(2) The agent shall be prohibited from authorizing consent for the following items:

This power of attorney for health care decisions shall become effective immediately and shall not be affected by my subsequent disability and incapacity or upon the occurrence of my disability or incapacity. Any durable power of attorney for health care decisions I have previously made is thereby revoked.

Executed this_____(date) at_____, Kansas

Signature_____

This document must be witnessed by two individuals or acknowledged by a notary public.

Witnesses:

Name_____
Address _____
City, State, Zip_____

Name_____
Address _____
City, State, Zip_____

OR Notary Public:

State of_____Country of_____ SS: This instrument was acknowledged before me this_____day of_____(month, year)

Signature of Notary:_____
My appointment expires:_____