DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

GENERAL STATEMENT OF AUTHORITY GRANTED

I, the undersigned, _____, designate and appoint

Agent 1: Name: _____

Address: _____

City, State: _____

Phone Number: _____

Relationship: _____

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

(1) Consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, and to make decisions about anatomical gifts (organ donation), autopsy, and disposition of the body, and to show particular concern for the cost and expense thereof;

(2) Make all necessary arrangements at any hospital, psychiatric hospital, or psychiatric treatment facility, hospice, nursing home, or similar institution, and 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 shall deem necessary for my physical, mental, and emotional well-being, and again to show particular concern for the cost and expense thereof;

(3) Act as my "personal representative," within the meaning of the Health Insurance Portability and Accountability Act ("HIPAA"), and in that capacity, to 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 releases of other documents that may be required in order to obtain such information. I further hereby authorize my attorney-in-fact to obtain for use and disclosure to third parties any of my protected health information and to execute any appropriate authorizations for the use or disclosure of my protected health information.

LIMITATIONS OF AUTHORITY

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 or subsequent declaration made in accordance with the Kansas Natural Death Act or a common law living will.

EFFECTIVE TIME

This Durable Power of Attorney for Health Care Decisions shall become effective and exercisable immediately and shall not be affected by my subsequent disability or incapacity.

SUBSTITUTE AGENT

If the person designated above (Agent 1) ceases to act as my agent due to death, resignation, removal, disability or incapacity (as determined by certification by a licensed physician), I appoint the following persons, in successive order of priority, to act as my substitute agent with all the same powers granted to the originally appointed agent (meaning Agent 2 shall act alone, and if he or she ceases to act as my agent due to death, resignation, removal, disability or incapacity (as determined by certification by a licensed physician) then Agent 3 shall act alone).

Agent 2:
Name: _____
Address: _____
City, State: _____
Phone Number: _____
Relationship: _____

Agent 3:
Name: _____
Address: _____
City, State: _____
Phone Number: _____
Relationship: _____

GUARDIAN

If protective proceedings are commenced on account of my disability or incapacity, I hereby nominate to the court the above-named agent or substitute agent to be my guardian.

REVOCATION

Any Durable Power of Attorney for Health Care Decisions I have previously made is hereby revoked. This Durable Power of Attorney for Health Care Decisions shall be revoked by an instrument in writing signed and acknowledged in the same manner as required herein.

SIGNATURE

Signed this ____ day of _____, 20____, at Salina, Kansas

_____
Signature

This document must be dated and signed in the presence of two witnesses or acknowledged by a notary public.

WITNESSES

The witnesses must not be (i) the agent; (ii) related to the principal by blood, marriage, or adoption; (iii) entitled to any portion of the principal's estate; or (iv) not financially responsible for principal's health care.

Witness _____ Witness _____

Address _____ Address _____

OR

NOTARY PUBLIC

STATE OF KANSAS, COUNTY OF _____, ss:

The foregoing instrument was acknowledged before me this ____ day of _____, 20____, by _____.

_____
Notary Public