California Durable Power of Attorney For Health Care

Warning To Person Executing This Document

This is an important legal document which is authorized by the Keene Health Care Agent Act. Before executing this document, you should know these important facts:

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent (1) authorizes anything that is illegal, (2) acts contrary to your known desires, or (3) where your desires are not known, does anything that is clearly contrary to your best interests.

The powers given by this document will exist for an indefinite period of time unless you limit their duration in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to

(1) authorize an autopsy,

(2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and

(3) direct the disposition of your remains.

This document revokes any prior durable power of attorney for health care.

You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You may also want to give your doctor an executed copy of this document.

Do not use this form if you are a conservatee under the Lanterman-Petris-Short Act and you want to appoint your conservator as your agent. You can do that only if the appointment document includes a certificate of your attorney.

CALIFORNIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

[PRINT YOUR NAME AND ADDRESS]

1. Designation of Health Care Agent.

I, ____________________ ***(name)***

of ____________________ ***(address)***

[PRINT NAME AND ADDRESS OF YOUR AGENT]

do hereby designate and appoint ____________________***(name of agent)***

_______________________________***(address and telephone number of agent)***

as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

2. Creation of Durable Power of Attorney for Health Care.

By this document I intend to create a durable power of attorney for health care under Sections 2430 to 2443, inclusive, of the California Civil Code. This power of attorney shall not be affected by my subsequent incapacity.

3. General Statement of Authority Granted.

Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

4. Statement of Desires, Special Provisions, and Limitations.

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

[ADD PERSONAL INSTRUCTIONS CONCERNING LIFE SUPPORT (IF ANY)]

(a) Statement of desires concerning life-prolonging care, treatment, services, and procedures:

[ADD OTHER PERSONAL INSTRUCTIONS (IF ANY)]

(b) Additional statement of desires, special provisions, and limitations:

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

5. Inspection and Disclosure of Information Relating to My Physical or Mental Health.

Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 ["Statement of Desires, Special Provisions, and Limitations"] above.)

6. Signing Documents, Waivers, and Releases.

Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

7. Autopsy; Anatomical Gifts; Disposition of Remains.

Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Authorize an autopsy under Section 7113 of the Health and Safety Code.

(b) Make a disposition of a part or parts of my body under the Uniform Anatomical Gift Act (Chapter 3.5 [commencing with Section 7150] of Part I of Division 7 of the Health and Safety Code).

(c) Direct the disposition of my remains under Section 7100 of the Health and Safety Code.

(If you want to limit the authority of your agent to consent to an autopsy, make an anatomical gift, or direct the disposition of your remains, you must state the limitations in paragraph 4 ["Statement of Desires, Special Provisions, and Limitations"] above.)

[SPECIFY A DURATION (IF ANY)]

8. Duration.

This durable power of attorney for health care expires on _________***(fill in this space ONLY if you want to limit the duration of this power of attorney)***

[PRINT THE NAMES, ADDRESSES AND TELEPHONE NUMBERS OF YOUR ALTERNATIVE AGENTS]

9. Designation of Alternate Agents.

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternate Agent: _______________________***(name of first alternate agent)***

____________________________***(address and telephone number of first alternate agent)***

B. Second Alternate Agent: ________________________***(name of second alternate agent)***

____________________________***(address and telephone number of second alternate agent)***

[PRINT THE NAME AND ADDRESS OF YOUR CONSERVATOR (OPTIONAL)]

10. Nomination of Conservator of Person.

(A conservator of the person may be appointed for you if a court decides that one should be appointed. The conservator is responsible for your physical care, which under some circumstances includes making health care decisions for you. You are not required to nominate a conservator but you may do so. The court will appoint the person you nominate unless that would be contrary to your best interests. You may but are not required to, nominate as your conservator the same person you named in paragraph 1 as your health care agent. You can nominate an individual as your conservator by completing the space below.)

If a conservator of the person is to be appointed for me, I nominate the following individual to serve as conservator of the person:

__________________________________***(name of person nominated as conservator)***

__________________________________***(address of person nominated as conservator)***

11. Prior Designations Revoked.

I revoke any prior durable power of attorney for health care.

[DATE AND SIGN THE DOCUMENT, AND PRINT THE CITY AND STATE IN WHICH YOU SIGNED IT]

DATE AND SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Durable Power of Attorney for Health Care on _________***(date)*** at ____________________ ,***(city)*** ________***(state)***

____________________ ***(you sign here)***

[*NOTE*:

YOU MAY SIGN THIS FORM *EITHER* IN THE PRESENCE OF A NOTARY PUBLIC *OR* IN THE PRESENCE OF TWO WITNESSES]

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY *EITHER* A NOTARY PUBLIC *OR* TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

[THIS SECTION MUST BE FILLED OUT BY A NOTARY PUBLIC]

EITHER

STATE OF CALIFORNIA)
COUNTY OF ________________)

On __________________ before me,
____ (here insert name and title of the officer), personally appeared
____
____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

_______________________________ (Seal)
Signature

[OR]

[YOUR WITNESSES MUST READ THIS STATEMENT AND SIGN BELOW]

OR

STATEMENT OF WITNESSES

(READ CAREFULLY BEFORE SIGNING. You can sign as a witness only if you personally know the principal or the identity of the principal is proved to you by convincing evidence.) (To have convincing evidence of the identity of the principal, you must be presented with and reasonably rely on any one or more of the following:

(1) An identification card or driver's license issued by the California Department of Motor Vehicles that is current or has been issued within five years.

(2) A passport issued by the Department of State of the United States that is current or has been issued within five years.

(3) Any of the following documents if the document is current or has been issued within five years and contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number:

(a) A passport issued by a foreign government that has been stamped by the United States Immigration and Naturalization Service.

(b) A driver's license issued by a state other than California or by a Canadian or Mexican public agency authorized to issue drivers' licenses.

(c) An identification card issued by a state other than California.

(d) An identification card issued by any branch of the armed forces of the United States.

(4) If the principal is a patient in a skilled nursing facility, a witness who is a patient advocate or ombudsman may rely upon the representations of the administrator or staff of the skilled nursing facility, or of family members, as convincing evidence of the identity of the principal if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the principal.)

(Other kinds of proof of identity are not allowed)

[*NOTE*: IF YOU ARE A PATIENT IN A NURSING HOME, A PATIENT ADVOCATE MUST BE ONE OF YOUR TWO WITNESSES AND MUST ALSO SIGN A SEPARATE STATEMENT AT THE END OF THIS DOCUMENT]

WITNESS #1:

I declare under penalty of perjury under the laws of California that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

Signature: ____________________

Print Name: ____________________

Residence Address: ____________________

Date: ____________________

WITNESS #2:

Signature: ____________________

Print Name: ____________________

Residence Address: ____________________

Date: ____________________

[AT LEAST ONE OF YOUR WITNESSES MUST ALSO READ AND SIGN THIS STATEMENT]

I further declare under penalty of perjury under the laws of California that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: ____________________

Signature: ____________________

[IF YOU ARE A PATIENT IN A NURSING HOME, THE PATIENT ADVOCATE MUST READ AND SIGN THIS STATEMENT]

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I further declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by subdivision (f) of Section 2432 of the Civil Code.