DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. 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, 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 THIS 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 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.

1. DESIGNATION OF HEALTH CARE AGENT

I, _____, residing in _____ County, hereby designate and appoint: _____

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 and 2443, inclusive, of the California Civil Code. This power of attorney is authorized by the Keene Health Care Agent Act and shall be construed in accordance with the provisions of Sections 2500 to 2506, 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 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 healthcare, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

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

1. I do NOT want efforts made to prolong my life and I do NOT want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state: or (2) if I am terminally ill and the application of life-sustaining procedures would serve only to artificially delay the moment of my death: or (3) under any other circumstances where the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatment.

_____
My initials

2. I want efforts made to prolong my life and I want life-sustaining treatment to be provided **unless I am in a coma or persistent vegetative state** which my doctor reasonably believes to be irreversible. Once my doctor has concluded that I will remain unconscious for the rest of my life, I do not want life-sustaining treatment to be provided or continued.

_____
My initials

3. I want efforts made to prolong my life and I want life-sustaining treatment to be provided **even if I** am in an irreversible coma or persistent vegetative state.

_____
My initials

(b) Additional statement of desired, special provision, and limitations:

1. I **DO** want my organs to be donated. _____
My initials

2. I **DO NOT** want my organs to be donated. _____
My initials

3. I **DO** want my organs to be donated limited to the following:

_____

_____
My initials

Further Statement of desires:

_____
_____
_____
_____

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations set forth elsewhere 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 information;
(c) Consent to the disclosure of medical information.

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 1 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.

8. DURATION

This durable power of attorney for health care shall remain in effect until I revoke it in writing.

9. DESIGNATION OF ALTERNATE AGENT

If the person designated as my agent herein 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 person to serve as my agent to make health care decisions for me as authorized in this document:

(a) Alternate Agent:

NAME :_____

ADDRESS :_____

_____

TELEPHONE NUMBER :_____

(b) Second Alternate Agent:

NAME :_____

ADDRESS :_____

_____

TELEPHONE NUMBER :_____

10. PRIOR DESIGNATIONS REVOKED

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

DATE AND SIGNATURE OF PRINCIPAL

I sign my name to this Statutory Form of Durable Power of Attorney for Health Care on _____, at _____County, California.

Signature: _____

THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE.

STATEMENT OF WITNESSES

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 healthcare provider, an employee of health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

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.

WITNESS:

DATED:_____ Signature: _____

Printed: _____

Address: _____

_____

DATED:_____ Signature: _____

Printed: _____

Address: _____

_____

COPIES

YOUR AGENT MAY NEED THIS DOCUMENT IMMEDIATELY IN CASE OF AN EMERGENCY THAT REQUIRES A DECISION CONCERNING YOUR HEALTH CARE. YOU SHOULD KEEP THE EXECUTED ORIGINAL DOCUMENT AND GIVE A COPY OF THE EXECUTED ORIGINAL TO YOUR AGENT AND ANY ALTERNATE AGENTS. YOU SHOULD ALSO GIVE A COPY TO YOUR DOCTOR, MEMBERS OF YOUR FAMILY, AND ANY OTHER PEOPLE WHO WOULD BE LIKELY TO NEED A COPY OF THIS FORM TO CARRY OUT YOUR WISHES. PHOTOCOPIES OF THIS DOCUMENT CAN BE RELIED UPON AS THOUGH THEY WERE ORIGINALS.