Power of Attorney for Health Care Living Will
of
PrincipalFirstName PrincipalMiddleName PrincipalLastName PrincipalSuffix

Article 1
Designation of Agents

1.01. I, PrincipalFirstName PrincipalMiddleName PrincipalLastName PrincipalSuffix, residing at StreetAddress Title, City, State ZipCode, do hereby designate and appoint, Agent1_firstName Agent1_middleName Agent1_lastName Agent1_Suffix, to serve as my agent to make health care decisions as authorized in this document. If Agent1_firstName Agent1_lastName fails to act or ceases to serve as my agent, then I designate Agent2_firstName Agent2_middleName Agent2_lastName Agent2_Suffix as my sole agent. My agent shall make health care decisions for me as authorized in this document.

1.02. For the purposes of this document, "health care decisions" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition.

Article 2
Creation of Power of Attorney For Health Care

2.01. By this document I intend to create a Power of Attorney for Health Care as authorized under Sections 4600 to 4805, inclusive, of the California Probate Code. This Power of Attorney for Health Care shall not be affected by my subsequent incapacity.

Article 3
Statement of Authority Granted

3.01. 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 those 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 lifeprolonging care, treatment, services, and procedures.

Article 4
Statement of Desires, Special Provisions, and Limitations

4.01. In exercising the authority under this Power of Attorney for Health Care, my agent shall act consistently with my desires and is subject to the special provisions and limitations stated below:

1. I do not want to be revived or resuscitated.
2. I do not want electrocardioversion.
3. I do not want mechanical respiration.
4. I do not want antibiotics.
5. I do not want kidney dialysis.
6. I do not want tube feeding or any other artificial or invasive form of nutrition(food).
7. I do not want any artificial or invasive form of hydration (water).
8. I do not want blood or blood products.
9. I do not want any form of life sustaining surgery or invasive diagnostic tests.
10. I do not want to allow physicians to try new medical discoveries on me.
11. I prefer to live my last days at home.

Article 5
HIPAA Health Information Release and Selection of Primary Physician

5.01. I intend my agent, as my "personal representative" as that term is used in the Health Insurance Portability and Accountability Act ("HIPAA"), 42 U.S.C. Section 1320d, 45 C.F.R. Parts 160 and 164 to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. The authority of my agent with respect to the use and disclosure of such information and records shall control my agent's dealings with any physician or other health care provider who is providing health care services to me at any time when my agent shall seek access to such information and/or records. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

1. Request, review, and receive from any physician or any other "covered entity" as defined under HIPAA, any information, verbal or written, regarding my physical or mental health, including, but not limited to, any medical and hospital records regarding any past, present or future physical or mental health conditions, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse;
2. Execute on my behalf any releases or other documents that may be required in order to obtain such information, including, but not limited to, a Valid Authorization under the Health Insurance Portability and Accountability Act; and
3. Consent to the disclosure of such requested information.

5.02. My agent shall at all times have the power and authority to select a primary physician for me as my agent deems appropriate; provided, however, that my agent shall at all times select as such primary physician the physician whom I would have chosen as my primary physician if I had been able to make such a choice (and my regular and continuous use of a particular physician shall be deemed sufficient evidence of what choice I would have made in this regard). It is my purpose in including this Article to indicate my understanding that I may change primary physicians from time to time and, to the extent such changes are known to my agent, I would like my agent to use such knowledge to override any contradictory provisions contained in this Power of Attorney for Health Care.

Article 6
Signing Documents, Waivers, and Releases

6.01. 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:

1. Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."
2. Any necessary waiver or release from liability required by a hospital or physician.
3. Any necessary instruments, and to perform all necessary acts required for the execution and implementation of all authorizations contained in this document.

Article 7
Additional Requests

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

Make a donation of a part or parts of my body.

Authorize an autopsy, if required by law or if my agent determines there is a compelling reason which would benefit mankind or my family.

Direct the disposition of my remains.

Article 8
Duration of Power

8.01. THIS POWER OF ATTORNEY SHALL BE EFFECTIVE ONLY UPON THE DISABILITY OR INCAPACITY OF THE PRINCIPAL, AND THEREAFTER THIS POWER OF ATTORNEY SHALL NOT BE AFFECTED BY DISABILITY OF THE PRINCIPAL OR LAPSE OF TIME, it being my intention that my agent shall have all of the powers enumerated in this document only if I am incapable of acting on my own behalf. For purposes of this paragraph, my disability or incapacity shall be determined by two (2) written certifications signed by a physician that he or she believes I am incapable of acting on my own behalf. Such incapacity shall be deemed to continue until delivery of two (2) similar certifications by such person(s) to my agent that I have regained my capacity to act on my own behalf.

Article 9
Nomination of Conservator

9.01. I nominate, Conservator1_firstName Conservator1_middleName Conservator1_lastName Conservator1_Suffix, as the conservator of my person, if one is ever needed. If Conservator1_firstName Conservator1_middleName Conservator1_lastName Conservator1_Suffix fails to act or ceases to serve as the conservator of my person, then I designate Conservator2_firstName Conservator2_middleName Conservator2_lastName Conservator2_Suffix as my conservator.

9.02. My conservator shall serve without bond. I revoke all prior conservatorship nominations.

Article 10
Reliance on Photocopies

10.01. Any person dealing with the agent shall have the right to rely on a photocopy of this Power of Attorney for Health Care as if it were the signed original Power of Attorney for Health Care.

Article 11
Prior Designations Revoked

11.01. I revoke any prior Durable Power of Attorney for Health.

Article 12
Declaration of Principal

12.01. I declare that I understand my rights in connection with this instrument and the consequences of signing it and not signing it.

Date and Signature of Principal

I sign my name to this Power of Attorney for Health Care on _____, at City, State ZipCode.

_____
PrincipalFirstName PrincipalMiddleName PrincipalLastName PrincipalSuffix

Statement of Witnesses

We declare (1) that the individual who signed or acknowledged this advance health care directive is personally known to us, or that the individual's identity was proven to us by convincing evidence, (2) that the individual signed or acknowledged this advance directive in our presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that we are not a person appointed as agent by this advance directive, and (5) that we are not the individual's health care provider, an employee of the individual's 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: _____

Name: _____

Address: _____

_____

Signature: _____

Name: _____

Address: _____

_____

Acknowledgment

State of State

County of County

On _____, before me, _____, personally appeared PrincipalFirstName PrincipalMiddleName PrincipalLastName PrincipalSuffix, 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 instrument in his/her/their authorized capacit(y/ies) and that by his/her/their signature(s) on the instrument the person(s), or the entity on 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.

Signature_____