DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

This is a Durable Power of Attorney for Health Care Decisions, and the authority of my agent shall not terminate if I become incapacitated. I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in my Health Care Treatment Directive or otherwise known to my agent. My agent's authority to interpret my desires is intended to be as broad as possible and any that expenses incurred should be paid by my resources. My agent may not delegate the authority to make decisions. My agent is authorized as follows to:

If there is a statement in paragraphs 1 through 6 below with which you do not agree, draw a line through it and add your initials.

1. Consent, refuse or withdraw consent to any care, treatment, service or procedure, (including artificially supplied nutrition and/or hydration by tube feedings) used to maintain, diagnose or treat a physical or medical condition.
2. Make decisions regarding organ donation, autopsy and the disposition of my body.
3. Make all necessary arrangements for any hospital, psychiatric hospital or treatment facility, nursing home or similar institution; to employ or discharge heal care personnel (any person who is, licensed, certified or otherwise authorized or permitted by the law of the State of Kansas to administer health care) as the agent shall deem necessary for my physical, mental and emotional well being.
4. 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 exempt any releases of other documents that may be required in order to obtain such information.
5. Move me into or out of any state for the purpose of complying with my Health Care Treatment Directive or the decisions of my agent.
6. Take any legal action reasonably necessary to do what I have directed.

I appoint the following person to be my agent to make health care decisions for me WHEN AND ONLY WHEN I lack the capacity to make or communicate a choice regarding a particular health care decision and my Health Care Treatment Directive does not adequately cover circumstances. I request that the person serving as my agent be my guardian if one is needed.

If you do not wish to name an agent, write NONE in the space provided below

AGENT'S NAME (Resident) ________________________________

ADDRESS ____TELEPHONE_____________________

If my agent is not available or not willing to make health care decisions for me, I appoint the person or persons named below in the order named if more than one is listed as my agent.

FIRST ALTERNATE AGENT

Name _______________________________

Address______________________________

Telephone____________________________

SECOND ALTERNATE AGENT

Name __________________________________

Address ________________________________

Telephone ______________________________

Protection of Persons Who Rely on My agent: I and my estate hold my agent and my caregivers harmless and protect them against any claim for following this durable power of attorney.
Severability: If any part of this document is held to be unenforceable under law, I direct that all of the other provisions of the document shall remain in force and effect.

X SIGNATURE __________________________________ DATE _________________________

Witness _______________________ Date ________ Witness ________________________ Date__________