

DURABLE POWER OF ATTORNEY FOR HEALTHCARE FOR

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document that is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen (18) years of age for this document to be legally valid and binding.

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.

This document gives your agent authority to request, consent to, refuse to consent to, or to withdraw consent for any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition if you are unable to do so yourself. This power is subject to any statement of your desires and any limitation 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 authorizes anything that is illegal; acts contrary to your known desires; or where your desires are not known, does anything that is clearly contrary to your best interest.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death.

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.

This document revokes any prior durable power of attorney for healthcare.

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, if any, or give each of them an executed copy of this document. You should give your doctor an executed copy of this document.

1. DESIGNATION OF A HEALTH CARE AGENT.

I, _____, of _____ (City and State), Phone # _____ do hereby designate and appoint (insert name, address, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: your treating health care provider, a nonrelative employee of your treating health care provider, an operator of a long-term care facility, or a nonrelative employee of an operator of a long-term care facility): _____, of _____

(Name, address and phone #) , 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.

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 my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures. (If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4 below. You can indicate your desires by including a statement of your desires in the same paragraph.)

HIPAA RELEASE AUTHORITY. I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed

by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFT 160-164. I authorize:

- a.any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau Inc or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services
- b.to give, disclose and release to my agent, without restriction,
- c.all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS AND LIMITATIONS.

(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.

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:

d.Statement of desires concerning life-prolonging care, treatment, services, and procedures:

e.Additional statement of desires, special provisions, and limitations regarding health care decisions:

(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.) If you wish to make a gift of bodily organ you may do so pursuant to North Dakota Century Code chapter 23-06.2, the Uniform Anatomical Gift Act.

DECLARATION

I. I, declare that on _____, 20__ : I have made the following decision concerning life-prolonging treatment: **(initial only one statement)**:

1. () I direct that life-prolonging treatment be withheld or withdrawn and that I be permitted to die naturally if two (2) physicians certify that:

A. I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in my imminent death; and

B. The application of life-prolonging treatment would serve only to artificially prolong the process of my dying; and

C. I am not pregnant.

It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and that they accept the consequences of that refusal, which is death.

2. () I direct that life-prolonging treatment, which could extend my life, be used if two (2) physicians certify that I am in a terminal condition that is an incurable or irreversible condition which, without the administration of life-prolonging treatment, will result in my imminent death. It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to direct that medical or surgical treatment be provided.

3. () I make no statement concerning life-prolonging treatment.

II. I have made the following decision concerning the administration of nutrition when my death is imminent: (initial one statement):

1. () I wish to receive nutrition.

2. () I wish to receive nutrition unless I cannot physically assimilate nutrition, nutrition would be physically harmful or would cause unreasonable physical pain, or nutrition would only prolong the process of my dying.

3. () I do not wish to receive nutrition.

4. () I make no statement concerning the administration of nutrition.

III. I have made the following decision concerning the administration of hydration when my death is imminent: (initial one statement):

1. () I wish to receive hydration.

2. () I wish to receive hydration unless I cannot physically assimilate hydration, hydration would be physically harmful or would cause unreasonable physical pain, or hydration would only prolong the process of my dying.

3. () I do not wish to receive hydration.

4. () I make no statement concerning the administration of hydration.

Concerning the administration of nutrition and hydration, I understand that if I make no statement about nutrition or hydration, my attending physician may withhold or withdraw nutrition or hydration if the physician determines that I cannot physically assimilate nutrition or hydration or that nutrition or hydration would be physically harmful or would cause unreasonable physical pain.

Additional statement of desires, special provisions, and limitations regarding health care decisions:

If you wish to make a gift of any bodily organ you may do so pursuant to North Dakota Century Code Chapter 23-06.2, the Uniform Anatomical Gift Act.

I (do / do not) () authorize, at the time of my death, all or part of my body to be used by any hospital, physician, surgeon, or procurement organization for transplantation, therapy, medical or dental education, research, or advancement of medical or dental science.

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 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 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. DURATION.

(Unless you specify a shorter period in the space below, this Power of Attorney will exist until it is revoked.) This Durable Power of Attorney for Healthcare expires on

_____. **(Fill in this space ONLY if you want the authority of your agent to end on a specific date).**

8.DESIGNATION OF ALTERNATE AGENTS.

(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved. Your agent may withdraw whether or not you are capable of designating another agent.)

If the person or persons designated as my agent in paragraph one (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 person 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:
(Insert name, address and telephone # of 1st Alternative Agent)

- b. Second Alternate Agent:
(Insert name, address and telephone # of 2nd Alternative Agent)

9. PRIOR DESIGNATIONS REVOKED.

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

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 _____,
20___, at _____.

(your signature)

THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS NOTARIZED OR SIGNED BY TWO (2) QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ANY ATTACHED 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.

NOTARY PUBLIC OR STATEMENT OF WITNESSES

This document must be (1) notarized or (2) witnessed by two qualified adult witnesses. The person notarizing this document may be an employee of a health care or long-term care provider providing your care. At least one witness to the execution of the document must not be a health care or long-term care providing you with direct care or an employee of the health care or long-term care provider providing you with direct care. None of the following may be used as a notary or witness:

61720.A person you designate as your agent or alternate agent;

61721.Your spouse;

61722.A person related to you by blood, marriage or adoption;

61723.A person entitled to inherit any part of your estate upon your death; or

61724.A person who has, at the time of executing this document, any claim against your estate.

Option 1: Notary Public

In my presence on _____(date), _____(name of declarant-the person making this Power of Attorney) acknowledged the declarant's signature on this document or

acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

Notary Public

(SEAL)

Option 2: Two Witnesses

Witness One:

(1) In my presence on _____ (date), _____ (name of declarant-the person making this Power of Attorney), acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

(2) I am at least eighteen years of age.

(3) If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial this box: [_____]

I certify that the information in (1) through (3) is true and correct.

(signature of witness one)

(address)

Witness Two:

(1) In my presence on _____ (date), _____ (name of declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

(2) I am at least eighteen years of age.

(3) If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial this box [_____].

I certify that the information in (1) through (3) is true and correct.

(signature of witness two)

(address)

10. ACCEPTANCE OF APPOINTMENT OF POWER OF ATTORNEY

I accept this appointment and agree to serve as agent for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapable. I understand that I must act in good faith in exercising my authority under this Power of Attorney. I understand that the principal may revoke this Power of Attorney at any time in any manner.

If I choose to withdraw during the time the principal is competent I must notify the principal of my decision. If I choose to withdraw when the principal is incapable of making the principal's health care decisions, I must notify the principal's physician.

Date: _____
_____, Agent

Date: _____
_____,
First Alternate Agent

Date: _____

Second Alternate Agent