HEALTH CARE POWER OF ATTORNEY

1. Designation of Health Care Agent.

I, _____, being of sound mind, hereby appoint

Name:
Home Address: _____
Home Telephone Number: _____
Work Telephone Number: _____
as my health care attorney in fact (herein referred to as my "Health Care Agent") to act for me and in my name (in any way I could act in person), to make health care decisions for me, as authorized in this document.

If the person named as my Health Care Agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint

A. Name:
Home Address: _____
Home Telephone Number: _____
Work Telephone Number: _____

The successor Health Care Agent shall be vested with the same powers and duties as if originally named as my Health Care Agent.

2. Effectiveness of Appointment. Absent revocation, the authority granted in this document shall become effective when and if my then attending physician or physicians determine that I lack sufficient understanding or capacity to make or communicate decisions relating to my health care and this authority shall continue in effect during my incapacity, until my death.

3. General Statement of Authority Granted. Except as indicated in Section 4 below, I hereby grant to my Health Care Agent named above full power and authority to make health care decisions, including mental health treatment decisions, on my behalf, including, but not limited to, the following:

(a) To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information;

(b) To employ or discharge my health care providers;

(c) To consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, or other institution;

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(d) To consent to and authorize my admission to and retention in a facility for the care or treatment of mental illness;

(e) To consent to and authorize the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment";

(f) To give consent for, to withdraw consent for, or to withhold consent for X ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, or podiatrist. This authorization specifically includes the power to consent to measures for relief of pain;

(g) To authorize the withholding or withdrawal of life sustaining procedures when and if my physician determines that I am terminally ill, permanently in a coma, suffer severe dementia, or am in a persistent vegetative state. Life sustaining procedures are those forms of medical care that only serve to artificially prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of medical treatment which sustain, restore, or supplant vital bodily functions. Life sustaining procedures do not include care necessary to provide comfort or alleviate pain.

(h) To exercise any right I may have to make a disposition of any part or all of my body for medical purposes, to donate my organs, to authorize an autopsy, and to direct the disposition of my remains; and

(i) To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

4. 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 ("HIPPA"), 42 U.S.C. § 1320d and 45 CFR § 160-164. Specifically, I authorize:

(a) Any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered healthcare provider, any insurance company and the Medical Information Bureau Inc., or other healthcare clearing house that has provided treatment or services to me, or that is paid for or is seeking payment from me for such services,

(b) To give, disclose and release to my Agent, without restriction, 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.

The forgoing authority given my Agent shall supercede any prior agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority, in writing, and deliver it to my healthcare provider.

5. Special Provisions and Limitations. If my primary care physician and one other physician determine that I am terminally ill, permanently in a coma, suffer severe dementia, or am in a persistent vegetative state, the authority of my Health Care Agent is subject to the following special provisions and limitations ("Yes" meaning I specifically authorize, "No" meaning I specifically decline, and "Unsure" meaning that I have no clear preference or wish to leave such decision to the sole discretion of my Agent):

	Yes	No	Unsure
A. **CPR:** Use drugs, electric shock and artificial breathing to bring me back to life when my heart stops.	☐	☐	☐
B. **Mechanical breathing:** Use a machine to do my breathing for me when I cannot breathe unaided.	☐	☐	☐
C. **Artificial nutrition:** Give me food through a tube in my vein or my stomach.	☐	☐	☐
D. **Artificial hydration:** Give me liquid through a tube in my vein.	☐	☐	☐
E. **Hospitalization:** Move me from home or hospice or nursing home to a hospital.	☐	☐	☐
F. **Major surgery:** Operate on something like a blockage in my stomach or remove my gall bladder.	☐	☐	☐
G. **Kidney dialysis:** Have a machine do the work of my kidneys – cleansing my blood – when they stop working on their own.	☐	☐	☐
H. **Chemotherapy:** Give me drugs to fight cancer.	☐	☐	☐
I. **Minor surgery:** Operate on something minor like an infected toe.	☐	☐	☐
J. **Major tests:** Do tests like heart catheterization or colonoscopy to see what's wrong inside me.	☐	☐	☐

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	Yes	No	Unsure
K. **Blood:** Transfuse blood or blood products into me if I am in need of them.	☐	☐	☐
L. **Antibiotics:** Give me drugs to fight diseases like pneumonia or a kidney infection.	☐	☐	☐
M. **Minor tests:** Do an x-ray or a blood test to see what's wrong with me.	☐	☐	☐
N. **Pain medication:** Give me enough medication so that I am not in pain.	☐	☐	☐
O. **Home:** Move me from the hospital so that I can die at home.	☐	☐	☐
P. **Other:**_____	☐	☐	☐

6. Guardianship Provision. If it becomes necessary for a court to appoint a guardian of my person, I nominate my Health Care Agent acting under this document to be the guardian of my person, to serve without bond or security.

7. Reliance of Third Parties on Health Care Agent

(a) No person who relies in good faith upon the authority of or any representations by my Health Care Agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions by my Health Care Agent.

(b) The powers conferred on my Health Care Agent by this document may be exercised by my Health Care Agent alone, and my Health Care Agent's signature or act under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my Health Care Agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my Health Care Agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

8. Miscellaneous Provisions

(a) I revoke any prior health care power of attorney.

(b) My Health Care Agent shall be entitled to sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient, or proper in

order to exercise and carry out any of the powers described in this document and to incur reasonable costs on my behalf incident to the exercise of these powers; provided, however, that except as shall be necessary in order to exercise the powers described in this document relating to my health care, my Health Care Agent shall not have any authority over my property or financial affairs.

(c) My Health Care Agent and my Health Care Agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns, and personal representatives from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my Health Care Agent pursuant to this document, except for willful misconduct or gross negligence.

(d) No act or omission of my Health Care Agent, or of any other person, institution, or facility acting in good faith in reliance on the authority of my Health Care Agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.

(e) If I have appointed more than one successor Health Care Agent, I direct that any of them shall be authorized to act alone as my Health Care Agent under this Health Care Power of Attorney, it being my express intent that any of my said Health Care Agents, acting alone, may perform any and all of the powers herein authorized to as fully an extent as if all of my said Health Care Agent were acting jointly in respect to said matters.

9. Signature of Principal

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my Health Care Agent.

This the _____ day of _____, 200_.

_____

Principal - _____

10. Signatures of Witnesses.

I hereby state that the principal, _____, being of sound mind, signed the foregoing Health Care Power of Attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate

Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor an employee of the health facility in which the principal is a patient, nor an employee of a nursing home or any group-care home where the principal resides. I further state that I do not have any claim against the principal.

_____
Witness

_____
Witness

STATE OF NORTH CAROLINA
COUNTY OF RANDOLPH

CERTIFICATE

I, _____, a Notary Public for Randolph County, hereby certify that the principal, _____, appeared before me and swore to me and to the witnesses in my presence that this instrument is a Health Care Power of Attorney, and that the principal willingly and voluntarily made and executed it as said principal's free act and deed for the purposes expressed in it. I further certify that _____ and _____, witnesses, appeared before me and swore that they witnessed the principal sign the attached Health Care Power of Attorney, believing the principal to be of sound mind; and also swore that at the time they witnessed the signing (i) they were not related within the third degree to the principal or the principal's spouse, and (ii) they did not know, nor have a reasonable expectation, that they would be entitled to any portion of the principal's estate upon the principal's death under any will or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending the principal, nor an employee of an attending physician, nor an employee of a health facility in which the principal was a patient, nor an employee of a nursing home or any group care home in which the principal resided, and (iv) they did not have a claim against the principal. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the ___ day of _____, 200_.

_____
_____, Notary Public

Commission expires _____

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