DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, ____ , am of sound mind,
PRINT OR TYPE YOUR FULL NAME

and I voluntarily make this designation.

I designate __________________________________ , my________________________ ,
INSERT NAME OF PATIENT ADVOCATE SPOUSE, CHILD, FRIEND, ETC.

living at ____
ADDRESS OF PATIENT ADVOCATE

as my patient advocate to make care, custody and medical treatment decisions for me in the event I become unable to participate in medical treatment decisions. If my first choice is unable or unwilling to serve, I designate

____, living at
NAME OF SUCCESSOR

____ as my patient advocate.
ADDRESS OF SUCCESSOR

The determination of when I am unable to participate in medical treatment decisions shall be made by my attending physician and another physician or licensed psychologist.

In making decisions for me, my patient advocate shall follow my wishes of which he or she is aware, whether expressed orally, in a living will, or in this designation.

My patient advocate has authority to consent to or refuse treatment on my behalf, and to arrange medical services for me, including admission to a hospice program, hospital or nursing care facility, and to pay for such services with my funds. In addition, my patient advocate has authority to make decisions regarding my mental health treatment and—upon my death— make decisions regarding organ donation. I have read and understand the HIPAA requirements stated on the back of this document and grant my patient advocate full rights to any medical records to which I have a right.

> I expressly authorize my patient advocate to make a decision to withhold or withdraw treatment which would allow me to die and I acknowledge such decision could or would allow my death. My patient advocate can sign a do-not-resuscitate declaration for me. My patient advocate can refuse food and water administered to me through tubes or by any other means.
>
> ____
> SIGN YOUR NAME HERE IF YOU WISH TO GIVE YOUR PATIENT ADVOCATE THIS AUTHORITY

My specific wishes concerning health care are the following (if none, write "none"):

____

____

____

____

I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

It is my intent that my family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability for honoring my wishes as expressed in this designation or for implementing the decisions of my patient advocate.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I sign this document after careful consideration. I understand its meaning and I accept its consequences.

Dated: ______________________ Signed: ______________________

Address: ______________________

____

NOTICE REGARDING WITNESSES

You must have two adult witnesses who will not receive your assets when you die (whether you die with or without a Will), and who are not your parent, spouse, child, grandchild, brother or sister, physician or employee at the health care facility where you are a patient.

STATEMENT OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

Signed by witness: ______________________
SIGNATURE

____
PRINT OR TYPE FULL NAME

Address: ______________________

____

Signed by witness: ______________________
SIGNATURE

____
PRINT OR TYPE FULL NAME

Address: ______________________

____

The HIPAA Privacy Rule:
In short, the Privacy Rule ensures that your "protected health information" (PHI) cannot be shared without your permission. All entities who have access to your health records, such as hospitals, physicians, pharmacies and hospice providers, are required to abide by this law. The rule applies specifically to information that could be deemed "identifiable." Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number). By granting authority to your patient advocate, you are entrusting him or her to represent your privacy interests with respect to HIPAA.

ACCEPTANCE BY PATIENT ADVOCATE

(A) This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.

(B) A patient advocate shall not exercise powers concerning the patient's care, custody and medical treatment that the patient, if able to participate in the decision, could not have exercised on his or her own behalf.

(C) This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

(D) A patient advocate may make a decision to withhold or withdraw treatment, which would allow a patient to die, only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(E) A patient advocate shall not receive compensation for the performance or his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

(F) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interest. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.

(G) A patient may revoke his or her designation at any time or in any manner sufficient to communicate an intent to revoke.

(H) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

(I) A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act N. 368 of the Public Acts of 1978, being Section 333.20201 of the Michigan Compiled Laws.

I understand the above conditions and I accept the designation as patient advocate for:

____

Dated: ____________________ Signed: ____________________

Provided by Hospice of Michigan, www.hom.org. This document is for your information and is not designed to replace the advice of your attorney. REV. 3/11