CLAY COUNTY
MEDICAL CENTER
Our Family. Caring for Yours.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

GENERAL STATEMENT OF AUTHORITY GRANTED

I, the undersigned,_____, Date of Birth _____ designate and
(Name) (MM/DD/YYYY)
appoint Agent 1:

Name: _____
Address:_____
City, State: _____
Phone Number: _____
Relationship: _____

to act as my agent for health care decisions, when I am unable to make decisions or communicate what I want done, pursuant to the language stated below, on my behalf to:

(1) Consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, and to make decisions about organ donation, autopsy, and disposition of the body, and to show particular concern for the cost and expense thereof;

(2) Make all necessary arrangements at any hospital, psychiatric hospital, or psychiatric treatment facility, hospice, nursing home, or similar institution, and to employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists, or any other person who is licensed, certified, or otherwise authorized or permitted by the laws of this state to administer health care as the agent shall deem necessary for my physical, mental, and emotional well-being, and again to show particular concern for the cost and expense thereof;

(3) 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 execute any releases of other documents that may be required in order to obtain such information.

LIMITATIONS OF AUTHORITY

The powers of the agent herein shall be limited to the extent set out in writing in this Durable Power of Attorney for Health Care Decisions, and shall not include the power to revoke or invalidate any previously existing or subsequent declaration made in accordance with the Kansas Natural Death Act or a common law living will.

EFFECTIVE TIME

This Durable Power of Attorney for Health Care Decisions shall become effective and exercisable immediately and shall not be affected by my subsequent disability or incapacity or upon the occurrence of my disability or incapacity.

SUBSTITUTE AGENT

If the person designated above (Agent 1) ceases to act as my agent due to death, resignation, removal, disability or incapacity (as determined by certification by a licensed physician), I appoint the following persons in order of priority meaning Agent 2 shall act and if that agent ceases to act as my agent due to death, resignation, removal, disability or incapacity (as determined by certification by a licensed physician) then Agent 3 shall act, as my substitute agent with all the same powers granted to the originally appointed agent.

Agent 2: Name:_____
Address:_____
City, State: _____
Phone Number: _____
Relationship: _____

Agent 3: Name:_____
Address:_____
City, State: _____
Phone Number: _____
Relationship: _____

GUARDIAN

If protective proceedings are commenced on account of my disability or incapacity, I hereby nominate to the court the above-named agent or substitute agent to be my guardian.

REVOCATION

Any Durable Power of Attorney for Health Care Decisions I have previously made is hereby revoked. This Durable Power of Attorney for Health Care Decisions shall be revoked by an instrument in writing signed and acknowledged in the same manner as required herein.

SIGNATURE

Signed this_____day of_____, 20___at_____
(Day) (Month) (Insert city, state)

_____
Person Signing Power

STATE OF KANSAS, COUNTY OF CLAY, ss:

The foregoing instrument was acknowledged before me on this___day of_____, 20___, by_____.

_____
(notary stamp) Notary Public