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Kansas Heart HOSPITAL

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I, _____, designate and appoint:

Name: _____

Address:_____

Telephone No.: (_____) _____

to be my agent for healthcare decisions and 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;
2) Make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge healthcare 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 healthcare as the agent shall deem necessary for my physical, mental and emotional well-being; and
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.

Special Instructions and Limitations

In exercising the grant of authority set forth above, my agent for healthcare decisions shall be guided by the following special instructions:

_____

_____

(Please insert any special instructions you desire to be followed by your agent in exercising the authority you have granted).

Limitations of Authority

1) The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for healthcare decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the Natural Death Act (i.e. Living Will).
2) The agent shall be prohibited from authorizing consent for the following items:

   _____

   _____

   (Please insert any special instructions you desire to be followed by your agent in exercising the authority you have granted).
3) This durable power of attorney for healthcare decisions shall be subject to the additional following limitations:

   _____

   _____

   (Please insert any special instructions you desire to be followed by your agent in exercising the authority you have granted).

Designation of Alternate Agent

In the event the person designated above as my agent is not available and willing to make healthcare decisions for me, then I designate the following person to serve as my agent and make the healthcare decisions for me as authorized in this document.

First Alternate Agent

Name: _____

Address: _____

Telephone No.: (_____) _____

(continued on back)

Patient Information Label

Second Alternate Agent

Name: _____

Address: _____

Telephone No.: (_____) _____

Designation of Conservator or Guardian

In the event proceedings for a conservator or guardian are commenced pursuant to my incapacity, I nominate the above named agent (or alternative) to be the conservator or guardian, pursuant K.S.A. 58627(b), and amendments thereto or applicable statute.

Effective Time

This durable power of attorney for healthcare decisions shall become effective immediately and shall not be affected by my subsequent disability or incapacity or upon the occurrence of my disability or incapacity.

Revocation

By execution of this durable power of attorney for healthcare decisions, I revoke any prior durable power of attorney for healthcare decisions, but I do not revoke other powers of attorney, if any, which I have given concerning matters other than healthcare decisions.

I reserve the right to revoke this durable power of attorney for healthcare decisions by an instrument in writing signed by me and either (1) witnessed by two individuals meeting the same qualifications as set forth below, or (2) acknowledged by a notary public.

Execution

This document executed this _____ day of _____, 20_____, at _____

_____, Kansas.

_____, Principal

This document must be:

1) Witnessed by two individuals of lawful age who are not the agent, not related to the principal by blood or marriage or adoption, not entitled to any portion of principal's estate and not financially responsible for principal's healthcare: OR

2) Acknowledged by a notary public.

_____ _____

Witness Witness

_____ _____

Address Address

OR

STATE OF KANSAS)

) ss:

COUNTY OF_____

Now on this _____ day of _____, 20_____, before me the undersigned, a notary public in and for the county and sate aforesaid, came _____, who is personally known to me be the same person who executed this instrument and such person duly acknowledged the execution of same. In witness thereof, I have set my hand and affixed my seal the day and year written above.

_____

Notary

My appointment Expires: _____

Patient Information Label