Georgia Statutory Short Form
Durable Power of Attorney For Health Care

NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR AGENT) BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO REQUIRE, CONSENT TO, OR WITHDRAW ANY TYPE OF PERSONAL CARE OF MEDICAL TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION AND TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME, OR OTHER INSTITUTION, BUT NOT INCLUDING PSYCHOSURGERY, STERILIZATION, OR INVOLUNTARY HOSPITAL OR TREATMENT COVERED BY TITLE 37 OF THE OFFICIAL CODE OF GEORGIA ANNOTATED. THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS, BUT WHEN A POWER IS EXERCISED, YOUR AGENT WILL HAVE TO USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME CO-AGENTS AND SUCCESSOR AGENTS UNDER THIS FORM, BUT YOU MAY NOT NAME A HEALTH CARE PROVIDER WHO MAY BE DIRECTLY OR INDIRECTLY INVOLVED IN RENDERING HEALTH CARE TO YOU UNDER THIS POWER. UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW OR UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN IN THIS POWER THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED, INCAPACITATED, OR INCOMPETENT. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS, AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN CODE SECTIONS 31-36-6, 31-36-9, AND 31-36-10 OF THE GEORGIA "DURABLE POWER OF ATTORNEY HEALTH CARE ACT" OF WHICH THIS FORM IS A PART (SEE THE BACK OF THIS FORM). THAT ACT EXPRESSLY PERMITS THE USE OF ANY DIFFERENT FORM OF POWER OF ATTORNEY YOU MAY DESIRE. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

DURABLE POWER OF ATTORNEY made this _____ *day of* _____ *20* _____ .

1.I, _____ of _____, *(the city you live in)* _____*(the state you live in) hereby appoint:*

Agent's Name: _____
(Person you are appointing)

Agent's Address: _____

_____

Telephone Number (work): _____

(home): _____

Relation, if any: _____*as my attorney in fact (my agent) to act for me and in my name in any way I could act in person to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy of my body, and direct the disposition of my remains.*

THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF NOURISHMENT AND FLUIDS AND OTHER LIFE SUSTAINING OR DEATH-DELAYING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES TO LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY, OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS:

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as your own definition of when life-sustaining or death-delaying measures should be withheld; a direction to continue nourishment and fluids or other life-sustaining or death-delaying treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusions, electroconvulsive therapy, or amputation): _____

_____

_____

THE SUBJECT OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT IS OF PARTICULAR IMPORTANCE FOR YOUR CONVENIENCE IN DEALING WITH THAT SUJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT, BUT DO NOT INITIAL MORE THAN ONE.

- *I do not want my life to be prolonged nor do I want life-sustaining or death-delaying treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining or death-delaying treatment.*

_____
Initials

- *I want my life to be prolonged and I want life-sustaining or death-delaying treatment to be provided or continued unless I am in a coma, including a persistent vegetative state, which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered such an irreversible coma, I want life-sustaining or death-delaying treatment to be withheld or discontinued.*

_____
Initials

- *I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of the procedures.*

_____
Initials

THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU AT ANY TIME AND IN ANY MANNER WHILE YOU ARE ABLE TO DO SO. IN THE ABSENCE OF AN AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BE EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH AND WILL CONTINUE BEYOND YOUR DEATH IF AN ANATOMICAL GIFT, AUTOPSY, OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

3. ☐ *(place your initials here) This Power of Attorney shall become effective on* _____
(a future date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to first take effect).

4. ☐ *(place your initials here) This Power of Attorney shall terminate on* _____

IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH:

5. If any agent named by me shall die, become legally disabled, incapacitated, or incompetent, or resigns, refuses to act, or becomes unavailable, I name the following (each to act successively in the order named) as successors to such agent:

1st Successor Agent's Name: _____
(Person you are appointing)

Agent's Address: _____

_____

Telephone Number (work): _____

(home): _____

Relation, if any: _____

2nd Successor Agent's Name: _____
(Person you are appointing)

Agent's Address: _____

_____

Telephone Number (work): _____

(home): _____

Relation, if any: _____

IF YOU WISH TO NAME A GUARDIAN OF YOUR PERSON IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY INSERTING THE NAME OF SUCH GUARDIAN IN THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT THE PERSON NOMINATED BY YOU IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. YOU MAY, BUT ARE NOT REQUIRED TO, NOMINATE AS YOUR GUARDIAN THE SAME PERSON NAMED IN THIS FORM AS YOUR AGENT.

6. IF a guardian of my person is to be appointed, I nominate the following to serve as such guardian:

Guardian's Name: _____
(Person you are appointing)

Guardian's Address: _____

_____

Telephone Number (work): _____

(home): _____

Relation, if any: _____

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

_____ *(Your signature)*
(Principal)

The principal has had an opportunity to read the above form and has signed the above form in our presence. We, the undersigned, each being over 18 years of age, witness the principal's signature at the request and in the presence of the principal and in the presence of each other, on the day and year above set out.

Witnesses: *Addresses:*

1. _____ _____
Print *Street Address*

_____ _____
Sign *City – State – Zip Code*

2. _____ _____
Print *Street Address*

_____ _____
Sign *City – State – Zip Code*

Additional witness required when health care agency is signed in a hospital or skilled nursing facility. This additional witness should be attending physician, staff physician, or hospital designee (any of which participating in care of patient).

I hereby witness this health care agency and attest that I believe the principal to be of sound mind and to have made this health care agency willingly and voluntarily.

Attending Physician or other hospital designee witness: *Address:*

_____ _____
Print *Street Address*

_____ _____
Sign *City – State – Zip Code*

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

Specimen signatures of agent and successor(s) *I certify that the signature of my agent and successor(s) is (are) correct.*

_____ _____
(Agent) *(Principal)*

_____ _____
(Successor Agent) *(Principal)*

_____ _____
(Successor Agent) *(Principal)*

(a) The foregoing statutory health care power of attorney form authorizes, and any different form of health care agency may authorize, the agent to make any and all health care decisions on behalf of the principal which the principal could make if present and under no disability, incapacity, or incompetency, subject to any limitation on the granted powers that appear on the face of the form, to be exercised in such manner as the agent deems consistent with the intent and desires of the principal. The agent will be under no duty to exercise granted powers or to assume control of or responsibility for the principal's health care; but, when granted powers are exercised, the agent will be required to use due care to act for the benefits of the principal in accordance with the terms of the statutory health care power and will be liable for negligent exercise. The agent may act in person or through others reasonably employed by the agent for that purpose but may not delegate authority to make health care decisions. The agent may sign and deliver all instruments,

negotiate and enter into all agreements, and do all other acts reasonably necessary to implement the exercise of the powers granted to the agent. Without limiting the generality of the foregoing, the statutory health care power form shall, and any different form of health care agency may, include the following powers, subject to any limitations appearing on the face of the form:

(1) The agent is authorized to consent to and authorize or refuse, or to withhold or withdraw consent to, any and all types of medical care, treatment, or procedures relating to the physical or mental health of the principal, including any medication program, surgical procedure, life-sustaining or death-delaying treatment, or provision of nourishment and fluids for the principal, but not including psychosurgery, sterilization, or involuntary hospitalization or treatment covered by Title 37;

(2) The agent is authorized to admit the principal to or discharge the principal from any and all types of hospitals, institutions, homes residential or nursing facilities, treatment centers, and other health care institutions providing personal care or treatment for any type of physical or mental condition, but not including psychosurgery, sterilization, or involuntary hospitalization or treatment covered by Title 37;

(3) The agent is authorized to contract for any and all types of health care services and facilities in the name of and on behalf of the principal and to bind the principal to pay for all such services and facilities, and the agent shall not be personally liable for any services or care contracted for on behalf of the principal;

(4) At the principal's expense and subject reasonable rules of the health care provider to prevent disruption of the principal's health care, the agent shall have the same right the principal has to examine and copy and consent to disclosure of all the principal's medical records that the agent deems relevant to the exercise of the agent's powers, whether the records relate to mental health or any other medical condition and whether they are in possession of or maintained by any physician, psychiatrist, psychologist, therapist, hospital, nursing home, or other health care provider, notwithstanding the provisions of any statute or other rule of law to the contrary; and

(5) The agent is authorized to direct that an autopsy of the principal's body be made; to make a disposition of any part or all of the principal's body pursuant to Article 6 of Chapter 5 of Title 44, the Georgia Anatomical Gift Act, as now or hereafter amended; and to direct the disposition of the principal's remains.

31-36-11. This chapter applies to all health care providers and other persons in relation to all health care agencies executed on and after July 1, 1990. This chapter supersedes all other provisions of law or parts thereof existing on July 1, 1990 to the extent such other provisions are inconsistent with the terms and operation of this chapter, provided that this chapter does not affect the provisions of law governing emergency health care. If the principal has a living will under Chapter 32 of this title, as now or hereafter amended, the living will shall not be operative so long as an agent is available who is authorized by a health care agency to deal with the subject of life-sustaining or death-delaying procedures for and on behalf of the principal. Furthermore, unless the health care agency provides otherwise, the agent who is known to the health care provider to be available and willing to make health care decisions for the patient has priority over any other person, including any guardian of the person, to act for the patient in all matters covered by the health care agency.

31-36-12. This chapter does not in any way affect or invalidate any health care agency executed or any act of an agent prior to July 1, 1990, or affect any claim, right, or remedy that accrued prior to July 1, 1990.

31-36-13. This chapter is wholly independent of the provisions of Title 53, relating to wills, trusts, and the administration of estates, and nothing in this chapter shall be construed to affect in any way the provisions of said Title 53.

"Section 2. All laws and parts of laws in conflict with this act are repealed."