# Mississippi Durable Power of Attorney for Health Care
# Will to Live Form

## NOTICE TO PERSON EXECUTING THIS DOCUMENT

**This is an important legal document. Before executing this document you should know these important facts:**

**This document gives the person you designate as the attorney in fact (your agent) the power to make health care decisions for you. This power exists only as to those health care decisions to which you are unable to give informed consent. The attorney in fact must act consistently with your desires as stated in this document or otherwise made known.**

**Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.**

**Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.**

**This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent (a) authorizes anything is illegal, (b) acts contrary to your known desires, or (c) where your desires are not known, does anything that is clearly contrary to your best interests.**

**You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.**

**Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.**

**Unless you otherwise specify in this document, this document gives your agent the power after you die to (a) authorize an autopsy, (b) donate your body or parts**

**thereof for transplant or therapeutic or education or scientific purposes, and (c) direct the disposition of your remains.**

**If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.**

**This power of attorney will not be valid for making health care decisions unless it is either (a) signed by two (2) qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature or (b) acknowledged before a notary public in the state.**

## DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, (your name)_____

(your address)_____

_____

(your phone number)_____

hereby appoint:

(Name of agent)_____

(address of agent)_____

(phone number(s) of agent)_____

as my attorney in fact to make any health care decisions for me in the event that I become unable to give informed consent with respect to a given health care decision.

Subject to my special instructions below, this document gives my attorney in fact the full power to make health care decisions for me, before or after my death, to the same extent that I could make decisions for myself and to the full extent permitted by law, including power to grant, refuse, or withdraw consent on my behalf for any health care service, to make disposition under the state's anatomical gift act, to authorize autopsy, and to direct the disposition of remains. My attorney in fact also has the authority to talk to health care personnel, get information and sign forms necessary to carry out these decisions, and also the power provided in Sections 41-41-201 through 41-41-229, Mississippi Code of 1972, as now enacted or hereafter amended, being the statues governing the withdrawal of life-saving mechanisms.

Special instructions:

This designation shall become effective only when I become incapable of giving informed consent with respected to my own health care decisions.

Any prior designation is revoked.

## GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and health care attorney in fact(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care attorney in fact to provide me with food and fluids, orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery,

–all to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy.

I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person's death.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the "quality" of my life. I reject any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) and health care attorney in fact to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my attorney in fact, as named below, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my

health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

**WHEN MY DEATH IS IMMINENT**

A. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:
**(Be as specific as possible; SEE SUGGESTIONS.):**

_____
_____
_____
_____
_____
_____

(Cross off any remaining blank lines.)

**WHEN I AM TERMINALLY ILL**

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:
**(Be as specific as possible; SEE SUGGESTIONS.):**

_____
_____
_____
_____
_____
_____

(Cross off any remaining blank lines.)

**C. OTHER SPECIAL CONDITIONS**:
**(Be as specific as possible; SEE SUGGESTIONS.):**

_____
_____
_____
_____
_____
_____

(Cross off any remaining blank lines.)

**IF I AM PREGNANT**

D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care attorney in fact(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even if I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

_____

Signature of Declarant

If the person named as my attorney in fact is not available or is unable to act as my attorney in fact, I appoint the following persons to serve in his or her place (each to act alone and successively, in the order named)

A. First Successor Agent

(successor agent's name)_____

(successor agent's address)_____

_____

(successor agent's phone number)_____

B. Second Successor Agent

(second successor agent's name)_____

(second successor agent's address)_____

_____

(second successor agent's phone number)_____

as my attorneys in fact to make any health care decisions for me as authorized in this document consistent with the instructions above.

By my signature, I do hereby indicated that I understand the purpose and effect of this document.

(Signature)_____

(Date)_____

**- EITHER -**

**WITNESSES SIGNATURE**

I declare under penalty of perjury under the laws of Mississippi that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, nor an employee of a health care provider or facility.

First Witness Signature:_____

Residence Address:_____

Second Witness Signature:_____

Residence Address:_____

**TO BE SIGNED BY ONE OF THE WITNESSES:**

I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Witness Signature:_____

**-OR-**

**NOTARY PUBLIC**

State of Mississippi

County of _____

On this _____ day of _____, 20____,

before me, (name of notary public)_____ personally appeared, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledge that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Notary Seal

Signature of Notary Public_____

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