



# DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND/OR HEALTH CARE DIRECTIVE OF



(Print full name here) \_\_\_\_\_

(Address, City, State, Zip) \_\_\_\_\_



## PART I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(If you **DO NOT WISH** to name someone to serve as your decision-making Agent, mark an "X" through Part I on pages 1 & 2 and continue on to Part II.)

1. **Selection of Agent.** I, \_\_\_\_\_, currently a resident of \_\_\_\_\_ County, Missouri, appoint the following person as my true and lawful attorney-in-fact ("Agent"):

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone(s):** 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_



2. **Alternate Agent.** If my Agent resigns or is not able or available to make health care decisions for me, or if an Agent named by me is divorced from me or is my spouse and legally separated from me, I appoint the following persons in the order named below to serve as my alternate Agent and to have the same powers as my Agent:

**First Alternate Agent:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone(s):** 1<sup>st</sup> \_\_\_\_\_

2<sup>nd</sup> \_\_\_\_\_

**Second Alternate Agent:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone(s):** 1<sup>st</sup> \_\_\_\_\_

2<sup>nd</sup> \_\_\_\_\_

3. **Durability.** This is a Durable Power of Attorney, and the authority of my Agent, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

4. **Effective Date.** This Durable Power of Attorney is effective when I am incapacitated and unable to make and communicate a health-care decision as certified by (**check one of the following boxes**):

one physician **OR**  two physicians.

5. **Agent's Powers.** I grant to my Agent full authority to:

A. Give consent to, prohibit, or withdraw any type of health care, long-term care, hospice or palliative care, medical care, treatment, or procedure, either in my residence or a facility outside of my residence, even if my death may result, including, but not limited to, an out of hospital do-not-resuscitate order, with the following specific authorization (**initial one of the following boxes to indicate your choice**):

\_\_\_\_\_  
Initials

I wish to AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

\_\_\_\_\_  
Initials

OR I DO NOT AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

B. Make all necessary arrangements for health care services on my behalf and to hire and fire medical personnel responsible for my care;

Initials \_\_\_\_\_

Part I - After completed, detach, make copies and give to your health care providers.  
Durable Power of Attorney for Health Care and/or Health Care Directive

- C. Move me into, or out of, any health care or assisted living/residential care facility or my home (even if against medical advice) to obtain compliance with the decisions of my Agent;
- D. Take any other action necessary to do what I authorize here, including, but not limited to, granting any waiver or release from liability required by any health care provider and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney for Health Care;
- E. Receive information regarding my health care, obtain copies of and review my medical records, consent to the disclosure of my medical records, and act as my “personal representative” as defined in the regulations [45 C.F.R. 164.502(g)] enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”);



F. In addition to the powers set forth above, I authorize my Agent to do one or more of the following (*initial your desired choices*):

Initials

Determine what happens to my body after my death;

Initials

Give consent after my death to an autopsy or postmortem examination of my remains;

Initials

Delegate health care decision-making power to another person (“Delegee”) as selected by my Agent, and the Delegee shall be identified in writing by my Agent;



G. With respect to anatomical gifts of my body or any part (i.e., organs or tissues), please initial your desired choice below:

Initials

**AUTHORIZATION OF ANATOMICAL GIFTS.** I wish to AUTHORIZE my Agent to make an anatomical gift of my body or part (organ or tissue).

|   |  |
|---|--|
| <p>My donations are for the following purposes: (check one)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Transplantation</li> <li><input type="checkbox"/> Therapy</li> <li><input type="checkbox"/> Research</li> <li><input type="checkbox"/> Education</li> <li><input type="checkbox"/> All the above</li> </ul> | <p>GIFT SPECIFICATIONS: (check one)</p> <p>I would like to donate</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Any needed organs and tissues, as allowed by law.</li> <li><input type="checkbox"/> Any needed organs and tissues as allowed by law, with the following restrictions:</li> </ul> |
|---|--|

Initials

**PROHIBITION OF ANATOMICAL GIFTS.** I DO NOT AUTHORIZE my Agent to make an anatomical gift of my body or any part (organ or tissue).

**6. Agent’s Financial Liability and Compensation.** My Agent, acting under this Durable Power of Attorney for Health Care will incur no personal financial liability. My Agent shall not be entitled to compensation for services performed under this Durable Power of Attorney for Health Care, but my Agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions hereof.



## PART II. HEALTH CARE DIRECTIVE

**(If you DO NOT WISH to make a health care directive but only wish to have an Agent make your decisions without the directive, be sure that you have completed Part I on pages 1 & 2, mark an “X” through Part II on pages 2 & 3 and continue to Part III.)**



1. I make this HEALTH CARE DIRECTIVE (“Directive”) to exercise my right to determine the course of my health care and to provide clear and convincing proof of my choices and instructions about my treatment.

2. If I am persistently unconscious or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, I direct that all of the life-prolonging procedures that I have initialed below be withheld or withdrawn.

                      
Initials

**artificially supplied nutrition and hydration (including tube feeding of food and water)**

                      
Initials

**surgery or other invasive procedures**

                      
Initials

**heart-lung resuscitation (CPR)**

                      
Initials

**antibiotics**

                      
Initials

**dialysis**

                      
Initials

**mechanical ventilator (respirator)**

                      
Initials

**chemotherapy**

                      
Initials

**radiation therapy**

                      
Initials

**other procedures specified by me (insert) \_\_\_\_\_**

                      
Initials

**all other “life-prolonging” medical or surgical procedures that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury**

3. However, if my physician believes that any life-prolonging procedure may lead to a recovery significant to me as communicated by me or my Agent to my physician, then I direct my physician to try the treatment for a reasonable period of time. If it does not cause my condition to improve, I direct the treatment to be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

4. If I have already consented to be on the Missouri organ and tissue donor registry or my Agent has authorized the donation of my organs or tissues, I realize it may be necessary to maintain my body artificially after my death until my organs or tissues can be removed.

**IF I HAVE NOT DESIGNATED AN AGENT IN THE DURABLE POWER OF ATTORNEY, PART II OF THIS DOCUMENT IS MEANT TO BE IN FULL FORCE AND EFFECT AS MY HEALTH CARE DIRECTIVE.**

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### **PART III. GENERAL PROVISIONS INCLUDED IN THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE**

**1. Relationship Between Durable Power of Attorney for Health Care and Health Care Directive .** If I have executed both the Durable Power of Attorney for Health Care and Health Care Directive, I encourage my Agent to:

- A. First, follow my choices as expressed in the above Directive or otherwise from knowing me or having had various discussions with me about making decisions regarding life-prolonging procedures.
- B. Second, if my Agent does not know my choices for the specific decision at hand, but my Agent has evidence of my preferences, my Agent can determine how I would decide. My Agent should consider my values, religious beliefs, past decisions, and past statements. The aim is to choose as I would choose, *even if it is not what my Agent would choose for himself or herself.*

