# ***DURABLE POWER OF ATTORNEY FOR HEALTH CARE***

I, ________________________, reside in ____________________ County, New Mexico:

**(1) DESIGNATION OF AGENT:** I designate the following individual as my agent to make health-care decisions for me:

Name of Agent: ____________________________________________________________________

Agent's Address: ____________________________________________________________________

Agent's Telephone Number: ____________________________________________________________

**DESIGNATION OF SUCCESSOR AGENT(S)**
**(OPTIONAL)**

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health-care decision for me, I designate as my successor agent:

Name of Successor Agent: ____________________________________________________________

Successor Agent's Address: ___________________________________________________________

Successor Agent's Telephone Number: __________________________________________________

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health-care decision for me, I designate as my second successor agent:

Name of Second Successor Agent: _________________________________________________

Second Successor Agent's Address: __________________________________________________

Second Successor Agent's Telephone Number: _______________________________________

**(2) AGENT'S AUTHORITY:** My agent is authorized to obtain and review medical records, reports and information about me and to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of health care to keep me alive, except as I state here:

______________________________________________________________________________

______________________________________________________________________________

My agent shall be entitled to all of my medical information and records as my personal representative within the meaning of the Health Insurance Portability and Accountability Act.

**(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:**

***Please initial either A or B:***

*(A)*____________My agent's authority becomes effective immediately unless I have revoked the agent's authority.

*(B)* ____________My agent's authority shall become effective only if I become incapacitated. My agent shall be entitled to rely on notarized statements from two qualified health care professionals as to my incapacity.

**(4) AGENT'S OBLIGATION:** My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions which are in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

**(5) NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as guardian, I nominate the successor agent whom I have named, in the order designated.

**(6) DURABILITY:** This durable power of attorney for health care shall remain in effect despite my later incapacity.

## PART 2
## INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may cross out any wording you do not want.

**(7) END-OF-LIFE DECISIONS:** If I am unable to make or communicate decisions regarding my health care, and IF (i) I have an incurable or irreversible condition that will result in my death within a relatively short time, OR (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, OR (iii) the likely risks and burdens of treatment would outweigh the expected benefits, THEN I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below in one of the following two boxes:

[____________] (a) I CHOOSE NOT to Prolong Life
I do not want my life to be prolonged.

[____________] (b) I CHOOSE To Prolong Life
I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

**(8) ARTIFICIAL NUTRITION AND HYDRATION:** If I have chosen above NOT to prolong life, I also specify by marking my initials below:

[____________] I DO NOT want artificial nutrition OR
[____________] I DO want artificial nutrition

[____________] I DO NOT want artificial hydration unless required for my comfort OR
[____________] I DO want artificial hydration.

**(9) RELIEF FROM PAIN:** Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible to keep me clean, comfortable and free of pain or discomfort be provided at all times so that my dignity is maintained, even if this care hastens my death:

______________________________________________________________________

______________________________________________________________________

**(10) ANATOMICAL GIFT DESIGNATION:** Upon my death I specify as marked below whether I choose to make an anatomical gift of all or some of my organs or tissue:

***Please Initial only one box***

[____________] **I CHOOSE** to make an anatomical gift of all of my organs or tissue to be determined by medical suitability at the time of death, and artificial support may be maintained long enough for organs to be removed.

[____________] **I CHOOSE** to make a partial anatomical gift of some of my organs or tissue as specified below, and artificial support may be maintained long enough for organs to be removed. The following organs and tissue may be donated:

_______________________________________________________

[____________] **I REFUSE** to make an anatomical gift of any of my organs or tissue.

[____________] **I CHOOSE** to let my agent decide.

**(11) OTHER WISHES:** (If you wish to write your own instructions for either health care or end-of-life decisions, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

(Add additional sheets if needed. Sheets should be signed and dated.)

## PART 3
## PRIMARY PHYSICIAN

**(12)** I designate the following physician and/or facility as my primary physician:

______________________________________________________________________________
(name of physician)

______________________________________________________________________________
(address) (city) (state) (zip code)

______________________________________________________________________________
(phone)

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

______________________________________________________________________________
(name of physician)

______________________________________________________________________________
(address) (city) (state) (zip code)

______________________________________________________________________________
(phone)

**(13) EFFECT OF COPY:** A copy of this form has the same effect as the original unless the original has been revoked.

**(14) REVOCATION:** I understand that I may revoke this OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE at any time, and that if I revoke it, I should promptly notify my supervising health-care provider and any health-care institution where I am receiving care and any others to whom I have given copies of this power of attorney. I understand that I may revoke the designation of an agent either by a signed writing or by personally informing the supervising health-care provider.

**(15) SIGNATURES:** Sign and date the form here:

**SIGNATURE OF PERSON GIVING POWER OF ATTORNEY:**

| ______________________________ | ______________________________ | __________________ |
|---|---|---|
| Sign your name | Print your name | Date |

______________________________________________________________________
Address (Street, City , State, Zip)

**<u>It is recommended, but not required, that this form be witnessed.</u>**

**SIGNATURES OF WITNESSES:**

| First witness: | Second witness: |
|---|---|
| ______________________________<br>Sign your name | ______________________________<br>Sign your name |
| ______________________________<br>Print your name | ______________________________<br>Print your name |
| ______________________________<br>Date | ______________________________<br>Date |
| ______________________________<br>Address | ______________________________<br>Address |
| ______________________________<br>City, State , Zip | ______________________________<br>City, State, Zip |

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