DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

(Pursuant to Kansas Statutes Annotated, Sections 58-625 through 632)

I, (print your name) ______________________________ designate and appoint: (print your agent's name)

Agent: ______________________________ to be my agent for health care decisions.

Agent's address: ______________________________

City ______________ State/Zip__________

Telephone: Daytime __________________ Evening __________________

If the person designated above is unavailable or unwilling to make health care decisions for me, then I designate the following person(s) to be my agent for healthcare decisions, to serve in the order listed below:

First Alternate Agent:

Name: ______________________________

Phone:______________________________

Address: ______________________________

City, State, Zip: ______________________________

Second Alternate Agent:

Name: ______________________________

Phone:______________________________

Address: ______________________________

City, State, Zip: ______________________________

AUTHORITY GRANTED

My healthcare agent may:

1. Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition.
2. Make all necessary arrangements at any hospital, treatment facility, hospice, nursing home or similar institution. Employ or discharge health care personnel including physicians, psychiatrists, dentists, nurses, therapists or other persons who are authorized or permitted by the laws of this state to administer health care as my agent shall deem necessary for my physical, mental and emotional well being.
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 execute any releases or other documents that may be required in order to obtain such information.
4. Make decisions about organ and tissue donations, autopsy and the disposition of my body.
5. My agent shall consider the following special instructions:(You may choose to write NONE. You may also choose to attach additional instructions.)

LIMITATIONS ON AUTHORITY GRANTED

1. The powers of the agent shall be limited to those set out in writing in this document and shall not include the power to revoke any previously existing declaration (Living Will) made in accordance with the Kansas Natural Death Act.

2. My agent may not authorize consent for the following items: (You may choose to write NONE. You may also choose to attach additional limitations.)

Nomination of Guardian and/or Conservator (Optional)

If I need a Guardian I nominate:

Name ____

Address ____

City, State, Zip _____________________________________

Telephone ____

If I need a Conservator I nominate:

Name ____

Address ____

City, State, Zip _____________________________________

Telephone ____

This power of attorney for health care decisions shall become effective when I am unable to make decisions or unable to communicate my wishes regarding health care. This power of attorney for health care decisions shall not be affected by my subsequent disability or incapacity. Any durable power of attorney for health care decisions I have previously made is hereby revoked.

Executed this __________ (day) of ____________________(month) ___________ (year)

at ____ (city, state)

Signature X ____

This document must be witnessed by two individuals or acknowledged by a notary public.

Witnesses:

Name: ________________________________ Name: ___________________________

Address: ______________________________ Address: __________________________

City, State, Zip: ________________________ City, State, Zip:_____________________

OR

Notary Public:

STATE OF__________________ COUNTY OF _________________
SS:_________________

This instrument was acknowledged before me this __________day of _____________________ (month, year)

Signature of Notary: ___________________________________

My appointment expires: ________________________________