Document Type: Advance Care Planning

ACPO01

METHODIST

Power of Attorney for Health Care

I, _____, the Principal, appoint_____, who is my_____, whose address is _____ and whose telephone number is_____as my **Attorney-in-Fact** for Health Care.

If the above named Attorney-in-Fact for Health Care is either unable or unwilling to act as my Attorney-in-Fact for Health Care, I hereby appoint_____, who is my_____, whose address is _____, and whose telephone number is _____as my **Successor Attorney-in-Fact** for Health Care.

I direct that my Attorney-in-Fact comply with the following instructions or limitations with regard to my Health Care wishes (this may include my wishes for, but are not limited to, instructions on life-sustaining treatment and artificially administered nutrition and hydration): _____

_____

I authorize my Attorney-in-Fact to make health care decisions for me, including life and death decisions, when it is determined by my treating provider(s) that I lack the capacity to make my own health care decisions. I understand that I may request a second opinion to confirm my capacity. In addition, I authorize the release of medical records to my Attorney-in- Fact or Successor Attorney-in-Fact, as set forth above. I have discussed or will discuss my Health Care wishes with my Attorney-in-Fact or Successor Attorney-in-Fact. I also understand that I can revoke this Power of Attorney for Health Care at any time by notifying my Attorney-in-Fact, my treating provider(s) or the facility in which I am a patient or resident.

I HAVE READ THIS POWER OF ATTORNEY FOR HEALTH CARE AND I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE HEALTH CARE, LIFE AND DEATH DECISION FOR ME, IF IT IS DETERMINED THAT I AM UNABLE TO MAKE SUCH DECISIONS.

_____ _____

Signature Address

_____ _____

Printed Name Date

THIS DOCUMENT **MUST BE** SIGNED BY A NOTARY PUBLIC **OR** TWO WITNESSES

State of _____) County of _____)

On this _____ day of _____20_____, before me, _____, a notary public in and for _____ County, _____ voluntarily signed this document in my presence. Witness my hand and notarial seal at _____in such county the day and year last written.

Notary Signature_____

OR

Declaration of Witnesses

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on the Power of Attorney for Health Care in our presence, and that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us, nor the principal's attending Physician, Nurse Practitioner, or Physician Assistant is the person appointed as Attorney-in-Fact.

_____ _____ _____ _____

Witness Signature Date Witness Signature Date

_____ _____

Printed Name Printed Name

_____ _____

Address Address

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD