Durable Power of Attorney For Health Care

I,_____, hereby appoint: _____
(Name)

_____
(Address)

as my attorney-in-fact (or "Agent") to make health care decisions for me if and when I am unable to make my own health care decisions. I grant to my Agent the power to consent to giving, withholding or stopping any health care treatment, service, or diagnostic procedure, and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation. Unless specifically limited as set forth below, my Agent is also authorized as follows:

(a) To have access to medical records and information to the same extent that I am entitled, including the right to disclose the contents to others;

(b) To authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service;

(c) To contract on my behalf for any health care related service or facility on my behalf, without my Agent incurring personal financial liability for the contracts;

(d) To authorize any medication or procedure intended to relieve pain, even though its use may lead to physical damage, addiction, or hasten the moment of, (but not intentionally cause) my death.

If the person named as my Agent is not available or is unable to act as my Agent, then I appoint the following persons to serve in the order listed below:

_____
(Name)

_____
(Home Address)

_____
(City) (State) (Zip)

Home Telephone _____ Work Telephone _____

_____
(Name)

_____
(Home Address)

_____
(City) (State) (Zip)

Home Telephone _____ Work Telephone _____

By this document I intend to create a durable power of attorney which shall be effective during any period in which, in the opinion of my Agent and attending physician, I am incapacitated and unable to make or communicate a choice regarding a particular health care decision.

My Agent's health care decision shall be subject to any statement of desires, special provisions and/or limitations set forth below:

STATEMENT OF DESIRES, SPECIAL PROVISIONS AND/OR LIMITATIONS CONCERNING LIFE PROLONGING CARE, TREATMENT, SERVICES, AND PROCEDURES. FOR EXAMPLE, PAIN RELIEF, MEDICATIONS, CARDIAC RESUSCITATION, MECHANICAL BREATHING, KIDNEY DIALYSIS, ARTIFICIAL FEEDING/FLUID BY TUBES;

(a) I want _____

_____

_____

(Please complete other side)

REV 03/06 30096275

(b) I do not want _____

_____

_____

_____

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

I sign my name to this form on _____ , 20_____.

My current home address is: _____

_____

_____
(You sign here)

WITNESSES:

I declare that the person who signed or acknowledged this document is personally known to me , that he/she signed or acknowledged this durable power of attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as Agent by this document, nor am I directly providing care to the patient. I further declare that I am not related to the person signing this document by blood, marriage, or adoption, and that to the best of my knowledge, I am not entitled to any part of his/her estate under will now existing or by operation of law.

FIRST WITNESS: _____
(Signature)

Home Address: _____

_____

Print Name: _____

Date: _____

SECOND WITNESS: _____
(Signature)

Home Address: _____

_____

Print Name: _____

Date: _____

Keep the signed original with your personal papers at home. Give signed copies to doctors, family, and the medical records department of those hospitals in which you are likely to be hospitalized.

Review your Durable Power of Attorney for Health Care from time to time. Initial and date it to show it still expresses your intent

Billings Clinic

2800 Tenth Avenue North
P.O. Box 37000
Billings, MT 59107