DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This paper says who I want to make health care decisions for me. I want them to do this only if I am too sick to decide for myself. I want them to try to make the same decisions that I would make if I could.

I want this person to have all the legal rights to OK, refuse or stop medical care for me for a physical or mental condition. If I need it for mental illness or serious emotional disturbance, I want them to hospitalize me.

I want this person to have all the rights I have under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This person can get copies of all my medical information.

I want this person to have my durable power of attorney.

I want them to have the power to do the things listed above:

Name: _____

Street Address: _____

City: _____ State: _____

Day time phone: _____

Night time phone: _____

Backup attorney in fact:

If the person named above cannot or will not serve, I want the following person as my backup attorney in fact. I want them to have full powers and responsibilities to make health care decisions for me.

Name: _____

Street Address: _____

City: _____ State: _____

Day time phone: _____

Night time phone: _____

I give my OK to use copies of this legal paper. I am signing this Durable Power of Attorney for Health Care on the _____ day of _____, 20____.

My signature: X_____

Person giving the Durable Power of Attorney for Health Care (Principal)

Do you have a Living Will? If NO, stop here.

Read this if you have a Living Will. Fill out the part below:

Does my doctor think I will die no matter what they do?

Then I want this person to make sure my Living Will is followed. I want them to make sure that I die naturally. This means:

- Not dragging out my dying with machines or treatment that won't help.
- Giving me only what I need to be comfortable and out of pain.

Does my doctor think I will die no matter what they do? Then this is what else I want.

I may not be able to eat or drink. In that case: I **DO** ☐ or **DO NOT** ☐ give this person the right to say no to or to stop having me fed through a tube or a vein.

When I am dying, I want treatment and medicine to keep me comfortable and out of pain. In that case:

I **DO** ☐ or **DO NOT** ☐ give this person the right to OK **any** treatment or medicine to do that.

I want this treatment and medicine even if it could hurry my death. I want it even if it could cause addiction. I want it even if it could cause permanent physical damage.

My signature: X_____

Date: _____

5/04 LEGAL AID SOCIETY OF MIDDLE TENNESSEE AND THE CUMBERLANDS

Witnesses Statement

By signing this paper, each witness is saying that : "I know the person who signed this paper and asked me to be a witness. This person is an adult. This person signed the paper in front of me. I believe this person is in their right mind and knows what they are signing. I believe no one forced this person to sign the paper. I believe no one talked this person into signing this paper. This person understands what will happen because they signed this paper. I am not related to this person by blood, marriage or adoption. I will not get any of their estate when they die. I am not the person this paper makes the attorney in fact. I am not the attending doctors. I do not work for the doctor or a health facility where the person signing this paper is a patient. I do not now have a claim against any of this person's estate when they die."

_____ _____

Signature of Witness Signature of Witness

Date: _____ Date: _____

STATE OF TENNESSEE
COUNTY OF _____

Subscribed, sworn to and acknowledged before me by _____, the principal, and subscribed and sworn to before me by _____ and _____, witnesses, this _____ day of _____, 20___.

_____ My commission expires: _____

Notary Public

- WARNING -

This is an important legal document. Before executing this document you should know these important facts:

This document gives the person you designate as your agent (your attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent: (1) authorizes anything that is illegal; or (2) acts contrary to your desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to: (1) authorize an autopsy; (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes; and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask an attorney to explain it to you.

[Tennessee Code Annotated, § 34-6-205; Durable Power of Attorney for Health Care]