It is strongly recommended you contact legal counsel when completing this document.

IOWA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(Medical Power of Attorney)

I (the "Principal") hereby designate _____ ,
(Type or Print) First Name Last Name

_____
(Type or Print) Street Address City State Zip Code

as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of the State of Iowa, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including 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 statement of my desires and any limitations included in this document. My agent has the right to examine my medical records and to consent to disclosure of such records.

NOTE: (The Principal does not have to give any specific instructions or statement of desires but may do so.) Insert here specific instructions or statement of desires of principal (if any).

NOTE: (The Principal may designate one or more alternates as attorney in fact but does not have to.) If the person designated above is unable to serve,
I designate _____
(Type or Print) First Name Last Name

_____
(Type or Print) Street Address City State Zip Code

to serve as my attorney in fact.

Signed this _____ day of _____ , _____

_____
Signature of Principal (Person Granting the Power of Attorney)

_____
(Type or Print Name of Principal)

_____
Street Address

_____
City State Zip Code

This Power of Attorney must be witnessed by two persons or notarized.

STATE OF IOWA , COUNTY OF _____

This instrument was acknowledged before me on _____, by _____
_____
_____.

_____
_____, Notary Public

By signing this form I declare that I signed this form in the presence of the other witness and the Principal and I witnessed the signing by the Principal or other person acting on behalf of and at the Principal's direction.

_____
Signature of 1st Witness

_____
(Type or Print Name of Witness)

_____
Street Address

_____
City State Zip Code

_____
Signature of 2nd Witness

_____
(Type or Print Name of Witness)

_____
Street Address

_____
City State Zip Code

(Over)

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IOWADOCS®

General Information on Durable Power of Attorney for Health Care

A durable power of attorney for health care is subject to the provisions of Chapter 144B of the Code of Iowa and reference should be made to that chapter. The following is a summary of some of the provisions of Chapter 144B of the Code of Iowa.

1. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. "Health care" does not include the provision of nutrition or hydration except when they are required to be provided parenterally or through intubation.
2. The following individuals shall not be witnesses for a durable power of attorney for health care
   a. A health care provider attending the principal on the date of execution.
   b. An employee of a health care provider attending the principal on the date of execution.
   c. The individual designated in the durable power of attorney for health care as the attorney in fact
   d. An individual who is less than eighteen years of age.
3. One of the witnesses shall be an individual who is not a relative of the principal by blood, marriage, or adoption within the third degree of consanguinity.
4. The following individuals shall not be designated as the attorney in fact to make health care decisions under a durable power of attorney for health care:
   a. A health care provider attending the principal on the date of execution.
   b. An employee of a health care provider attending the principal on the date of execution unless the individual to be designated is related to the principal by blood, marriage, or adoption within the third degree of consanguinity.
5. Revocation.
   a. A durable power of attorney for health care may be revoked at any time and in any manner by which the principal is able to communicate the intent to revoke, without regard to mental or physical condition.
   b. Revocation may be made by notifying the attorney in fact orally or in writing.
   c. Revocation can also be made by notifying a health care provider orally or in writing while that provider is engaged in providing health care to the principal.
   d. A revocation is only effective as to a health care provider upon its communication to the provider by the principal or by another to whom the principal has communicated revocation.
   e. The health care provider is required to document the revocation in the treatment records of the principal.
   f. The principal is presumed to have the capacity to revoke a durable power of attorney for health care.
   g. Unless it provides otherwise, a valid durable power of attorney for health care revokes any prior durable power of attorney for health care.
6. Prohibited Practices.
   a. A health care provider, health care service plan, insurer, self-insured employee welfare benefit plan, or nonprofit hospital plan shall not condition admission to a facility, or the providing of treatment, or insurance, on the requirement that an individual execute a durable power of attorney for health care.
   b. A policy of life insurance shall not be legally impaired or invalidated in any manner by the withholding or withdrawing of health care pursuant to the direction of an attorney in fact appointed pursuant to this Chapter.
7. It is the responsibility of the principal to notify the health care provider (doctor) of the terms of the Durable Power of Attorney for Health Care.

SUGGESTIONS AFTER FORM IS PROPERLY SIGNED, WITNESSED OR NOTARIZED

1. Place original in a safe place known and accessible to family members or close friends.
2. Provide a true copy to your doctor.
3. Provide a copy(s) to family member(s).
4. Provide a copy to designated attorney in fact (agent) and to alternate designated attorney(s) in fact (if any).