DECLARATION

Pursuant to K.S.A. 65-28,101 through K.S.A. 65-28,109

Declaration made this _____ day of _____ (month, year). I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

City, County and State of Residence _____

The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care.

Witness _____

Witness _____

Durable Power of Attorney for Health Care Decisions

[Your Name]

[Address]

[City, State Zip Code]

Pursuant to K.S.A. 58-625 to K.S.A. 58-632, I appoint the following person as my attorney-in-fact for health care decisions:

[Primary Attorney-in-Fact Name]

[Primary Attorney-in-Fact Address]

[Primary Attorney-in-Fact City, State Zip Code]

If the above person should be unable to perform in this capacity due to death, disability, disqualification, or incapacity, then I appoint the following person as my attorney-in-fact:

[Alternate Attorney-in-Fact Name]

[Alternate Attorney-in-Fact Address]

[Alternate Attorney-in-Fact City, State Zip Code]

This is a durable power of attorney, and the authority of my attorney-in-fact shall not terminate if I become disabled or in the event of later uncertainty as to whether I am alive or dead. This durable power of attorney shall become effective immediately. This authority shall not include the ability to revoke or invalidate any declaration made in accordance with the Natural Death Act (a "Living Will" or similarly-titled document).

My attorney-in-fact shall have the authority to, on my behalf:

1. Consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, and to make decisions about organ donation, autopsy, and disposition of the body.

2. Make any and all arrangements at any hospital, psychiatric hospital, or psychiatric treatment facility, hospice, nursing home, or similar institution in Kansas or any other state or country; make arrangements for my release and removal from any institution; employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists, or any other person who is licensed, certified, authorized, or permitted by law to administer health care, as the agent shall deem necessary for my physical, mental, and emotional well being;

3. Request, receive, and review any verbal or written information regarding my personal affairs or physical or mental health, including medical and hospital records, to execute any releases that may be required to obtain this information, and to consent to the disclosure of this information. I hereby waive my patient-physician privileges in relation to this Durable Power of Attorney for Health Care Decisions. Further, I intend for my agent to be treated as I would be with respect to the use and disclosure of any individually-identifiable health information or other medical records pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320(d) and 45 C.F.R. 160-164.

I hereby revoke any previous Durable Power of Attorney for Health Care Decisions. This revocation does not extend to any previous General Durable Power of Attorney. I reserve the right to revoke this document by subsequent writing executed in the same manner as this document. This document shall continue in full effect until the earlier of the following: 1) my death; or 2) my revocation of this document.

Signed: _____ Dated: _____

State of Kansas

County of _____

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

_____

Notarial Officer

_____ My Appointment Expires: _____

Title

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