~~THE FOLLOWING FORM MAY BE USED TO GIVE HEALTH CARE INSTRUCTIONS, TO CREATE A POWER OF ATTORNEY FOR HEALTH CARE, OR BOTH. THIS FORM IS NOT INTENDED TO BE EXCLUSIVE, DIFFERENT FORMS MAY BE USED, AND AN INDIVIDUAL USING THIS FORM MAY COMPLETE BOTH PARTS OF THE FORM OR ONLY ONE PART.~~

~~ADVANCE MEDICAL DIRECTIVE~~

~~APPOINTMENT OF HEALTH CARE AGENT~~
~~(OPTIONAL FORM)~~

~~(CROSS THROUGH IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)~~

~~(1) I, _____, RESIDING AT _____~~
~~_____~~

~~APPOINT THE FOLLOWING INDIVIDUAL AS MY AGENT TO MAKE HEALTH CARE DECISIONS FOR ME: _____~~
~~_____~~
~~(FULL NAME, ADDRESS AND TELEPHONE NUMBER)~~

~~OPTIONAL: IF THIS AGENT IS NOT REASONABLY AVAILABLE OR IS UNABLE OR UNWILLING TO ACT AS MY AGENT, THEN I APPOINT THE FOLLOWING PERSON TO ACT IN THIS CAPACITY: _____~~
~~_____~~
~~(FULL NAME, ADDRESS AND TELEPHONE NUMBER)~~

~~(2) MY AGENT HAS FULL POWER AND AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING THE POWER TO:~~

~~1. REQUEST, RECEIVE, AND REVIEW ANY INFORMATION, VERBAL OR WRITTEN, REGARDING MY PHYSICAL OR MENTAL HEALTH, INCLUDING, BUT NOT LIMITED TO, MEDICAL AND HOSPITAL RECORDS, AND CONSENT TO DISCLOSURE OF THIS INFORMATION;~~

~~2. EMPLOY AND DISCHARGE MY HEALTH CARE PROVIDERS;~~

~~3. AUTHORIZE MY ADMISSION TO OR DISCHARGE FROM (INCLUDING TRANSFER TO ANOTHER FACILITY) ANY HOSPITAL, HOSPICE, NURSING HOME, ADULT HOME, OR OTHER MEDICAL CARE FACILITY; AND~~

~~4. CONSENT TO OR REFUSE THE PROVISION OF ANY TYPE OF HEALTH CARE INCLUDING LIFE-PROLONGING PROCEDURES.~~

~~(3) IN EXERCISING THE AUTHORITY UNDER THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE, THE AUTHORITY OF MY AGENT IS SUBJECT TO THE FOLLOWING SPECIAL PROVISIONS AND LIMITATIONS:~~

_____
_____