~~1.~~ *A.* REQUEST, RECEIVE, AND REVIEW ANY INFORMATION, ORAL 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.~~ *B.* EMPLOY AND DISCHARGE MY HEALTH CARE PROVIDERS;

~~3.~~ *C.* 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.~~ *D.* CONSENT TO ~~OR REFUSE~~ THE PROVISION, WITHHOLDING, OR WITHDRAWAL OF ~~ANY TYPE OF~~ HEALTH CARE, INCLUDING, IN APPROPRIATE CIRCUMSTANCES, ~~LIFE-PROLONGING~~ LIFE-SUSTAINING PROCEDURES.

(3) THE AUTHORITY OF MY AGENT IS SUBJECT TO THE FOLLOWING PROVISIONS AND LIMITATIONS:

_____

_____

_____

(4) MY AGENT'S AUTHORITY BECOMES OPERATIVE (INITIAL THE OPTION THAT APPLIES):

{ } _____ WHEN MY ATTENDING PHYSICIAN AND A SECOND PHYSICIAN DETERMINE THAT I AM INCAPABLE OF MAKING AN INFORMED DECISION REGARDING MY HEALTH CARE; OR

{ } _____ WHEN THIS DOCUMENT IS SIGNED.

(5) MY AGENT IS TO MAKE HEALTH CARE DECISIONS FOR ME BASED ON ~~ANY~~ THE HEALTH CARE INSTRUCTIONS I GIVE IN THIS DOCUMENT AND ON MY WISHES AS OTHERWISE KNOWN TO MY AGENT. IF MY WISHES ARE UNKNOWN OR UNCLEAR, MY AGENT IS TO MAKE HEALTH CARE DECISIONS FOR ME IN ACCORDANCE WITH MY BEST ~~INTERESTS~~ INTEREST, TO BE DETERMINED BY MY AGENT ~~IN LIGHT OF MY PERSONAL VALUES AS OTHERWISE KNOWN TO MY AGENT ON THE BASIS OF AN EVALUATION OF THE BENEFITS AND THE BURDENS THAT~~ *AFTER CONSIDERING THE BENEFITS, BURDENS, AND RISKS THAT* MIGHT RESULT FROM A GIVEN TREATMENT OR COURSE OF TREATMENT, OR FROM THE WITHHOLDING OR WITHDRAWAL OF A TREATMENT OR COURSE OF TREATMENT.

(6) MY AGENT SHALL NOT BE LIABLE FOR THE COSTS OF CARE BASED SOLELY ON THIS AUTHORIZATION.

BY SIGNING BELOW, I INDICATE THAT I AM EMOTIONALLY AND MENTALLY COMPETENT TO MAKE THIS APPOINTMENT OF A HEALTH CARE AGENT AND THAT I UNDERSTAND ITS PURPOSE AND EFFECT.

_____ _____

(DATE) (SIGNATURE OF DECLARANT)