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| State of Mississippi |  |
| **POWER OF ATTORNEY FOR MY HEALTH CARE**  A Simple Health Care Advance Directive | |

*This form combines the many different state legal requirements into a “universal” legal form that is intended to meet the basic requirements in most states. This form has space so you can add any special instructions or limitations you wish to include. But remember, this form is a basic Health Care Power of Attorney. It is not meant for a lengthy statement of your wishes and preferences. Remember, you should discuss your wishes and priorities directly with your agent and with others who are close to you.*

**INFORMATION ABOUT THE PRINCIPAL**

|  |  |  |  |
| --- | --- | --- | --- |
|  | |  | |
| **Principal’s**Full Name | |  | |
|  | | | |
| **Principal’s**Street Address | | | |
|  |  | |  |
| City | State | | Zip Code |
|  |  | | |
| **Principal’s**Daytime Phone | **Principal’s**Other Phone | | |
|  |  | | |
| **Principal’s**Birthday | **Principal’s**Email Address | | |

**WHO WILL BE YOUR HEALTH CARE AGENT?**

|  |  |  |
| --- | --- | --- |
|  | | |
| **Agent’s**Full Name | | |
|  | | |
| **Agent’s**Street Address | | |
|  |  |  |
| City | State | Zip Code |
|  |  | |
| **Agent’s**Daytime Phone | **Agent’s**Other Phone | |
|  |  | |
| **Agent’s**Email Address | | |

**WHO WILL BE YOUR BACK-UP AGENT(S)?**

If my first agent is unwilling or unable to act for any reason, then my next choice is:

|  |  |  |
| --- | --- | --- |
|  | | |
| **Back-Up Agent’s**Full Name | | |
|  | | |
| **Back-Up Agent’s**Street Address | | |
|  |  |  |
| City | State | Zip Code |
|  |  | |
| **Back-Up Agent’s**Daytime Phone | **Back-Up Agent’s**Other Phone | |
|  |  | |
| **Back-Up Agent’s**Email Address | | |

If the first two agents are not willing or able to act for any reason, then my next choice is:

|  |  |  |
| --- | --- | --- |
|  | | |
| **Second Back-Up Agent’s**Full Name | | |
|  | | |
| **Second Back-Up Agent’s**Street Address | | |
|  |  |  |
| City | State | Zip Code |
|  |  | |
| **Second Back-Up Agent’s**Daytime Phone | **Second Back-Up Agent’s**Other Phone | |
|  |  | |
| **Second Back-Up Agent’s**Email Address | | |

**WHAT WILL YOUR AGENT'S POWERS BE?**

My agent knows my goals and wishes based on our conversations and on any other guidance I may have written. My agent has full authority to make decisions for me about my health care according to my goals and wishes. If the choice I would make is unclear, then my agent will decide based on what he or she believes to be in my best interests. My agent's authority to interpret my wishes is intended to be as broad as possible, and includes the following authority: (Check all that apply)

1. To agree to, refuse, or withdraw consent to any type of medical care, treatment, surgical procedures, tests, or medications. **This includes decisions about using** **mechanical or other procedures that affect any bodily function, such as artificial respiration, artificially supplied nutrition and hydration (that is, tube feeding), cardiopulmonary resuscitation, or other forms of medical support, even if deciding to stop or withhold treatment could or would result in my death. \_\_\_\_\_\_** (**Principal’s initials**)

2. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose health information to others.

3. To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted-living or similar facility or service.

4. To contract for any health care-related service or facility for me, or apply for public or private health care benefits, with the understanding that my agent is not personally financially responsible for those contracts.

5. To hire and fire medical, social service, and other support personnel who are responsible for my care.

6. To authorize my participation in medical research related to my medical condition.

7. To agree to or refuse using any medication or procedure intended to relieve pain or discomfort, even though that use may lead to physical damage or dependence or hasten (but not intentionally cause) my death.

8. To decide about organ and tissue donations, autopsy, and the disposition of my remains as the law permits.

9. To take any other action necessary to do what I authorize here, including signing waivers or other documents, pursuing any dispute resolution process, or taking legal action in my name.

**DO YOU HAVE SPECIAL INSTRUCTIONS OR LIMITATIONS FOR YOUR AGENT?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WHEN WILL THIS POWER BE EFFECTIVE?**

This Power of Attorney for My Health Care will become effective during any time in which, in the opinion of my agent and attending physician, I am unable to make or communicate a choice about a particular health care decision.

**OTHER PROVISIONS**

1. Health care providers can rely on my agent**.** No one who relies in good faith on any representations by my agent or back-up agent will be liable to me, my estate, my heirs or assigns, for recognizing the agent's authority.

2. I cancel any previous power of attorney for health care that I may have signed.

3. I intend this power of attorney to be universal; it is valid in any jurisdiction in which it is presented.

4. I intend that copies of this document are as effective as the original.

5. My agent will not be entitled to compensation for services performed under this power of attorney, but he or she will be entitled to reimbursement for all reasonable expenses that result from carrying out any provision of this power of attorney.

**SIGNATURE**

I understand the contents of this document and the effect of granting powers to my agent.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **Principal’s** Signature |  |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **Principal’s** Name |  |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Date |  |  |

**A STATEMENT BY YOUR WITNESSES**

**First Witness**

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | | |
| **Witness**Signature | Date | | |
|  | | | |
| **Witness**Name | | | |
|  | | | |
| **Witness**Address | | | |
|  | |  |  |
| City | | State | Zip Code |

**Second Witness**

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | | |
| **Witness**Signature | Date | | |
|  | | | |
| **Witness**Name | | | |
|  | | | |
| **Witness**Address | | | |
|  | |  |  |
| City | | State | Zip Code |

**NOTARY ACKNOWLEDGEMENT OF PRINCIPAL**

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        )

                                                            )           **(Seal)**

County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       )

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_, by the undersigned, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who is personally known to me or satisfactorily proven to me to be the person whose name is subscribed to the within instrument.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTARY ACKNOWLEDGEMENT OF WITNESSES**

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        )

                                                            )           **(Seal)**

County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        )

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_, by the undersigned witnesses, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who are personally known to me or satisfactorily proven to me to be the person whose name is subscribed to the within instrument.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF NOTARY PUBLIC**

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_             )

                                                            )           **(Seal)**

County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_          )

On this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_, before me, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert name of notary public) appeared \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_