DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND/OR HEALTH CARE DIRECTIVE OF

	THI (D) OIL III		ECIIVE OI	
(Print full name here)				
(Address, City, State, Zip)				
(If you h	DO NOT WISH to 1		EY FOR HEALTH CA our decision-making Agent, continue on to Part II.)	RE
1. Selection of Agent. I, County	, Missouri, appoin	t the following person as	, currently a residency true and lawful attorney-in	dent of n-fact ("Agent"):
Name:				
Address:				
Phone(s):	1 st	2 nd		
named by me is divorced from order named below to serve as First Alternate Agent:	* *	ent and to have the same p		mig persons in the
Name:			er nate / Igent.	
Address:				
Phone(s): 1 st		Phone(s): 1	st	
2 nd		2	and 	
3. Durability . This is a Duror be void or voidable if I am of dead or alive.			of my Agent, when effective, ne event of later uncertainty a	
4. Effective Date as to Headecision making when I am in a (check one of the following be	capacitated and ur	nable to make and comm		
5. Agent's Powers. I grant	to my Agent full a	authority as to health care	decision making to:	
care, treatment, or pro result, including, but n	cedure, either in root limited to, an o	ny residence or a facility	ng-term care, hospice or palli outside of my residence, even ascitate order, with the follow technice):	n if my death may
		ent to direct a health care in (including tube feeding	provider to withhold or without of food and water);	lraw artificially
			n care provider to withhold on be feeding of food and water)	
B. Make all necessary arr responsible for my car		alth care services on my l	oehalf and to hire and fire me	dical personnel
Initials Part I - A	fter completed, detacl	h, make copies and give to you	r health care providers.	Page 1 of 4

Durable Power of Attorney for Health Care and/or Health Care Directive

Revised 2/14

C. Move me into, or out of, any health care or assisted living/residential care facility or my home (even if against medical advice) to obtain compliance with the decisions of my Agent; D. Take any other action necessary to do what I authorize here, including, but not limited to, granting any waiver or release from liability required by any health care provider and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney for Health Care; E. Receive information regarding my health care, obtain copies of and review my medical records, consent to the disclosure of my medical records, and act as my "personal representative" as defined in the regulations [45 C.F.R. 164.502(g)] enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); 6. Effective Date as to Other Authority. In addition to the powers set forth above. I authorize effective upon my signature and without the need for a physician's certification of incapacity that my Agent be authorized to have one or more of the following powers (initial your desired choices): Determine what happens to my body after my death (authority for right of sepulcher); Initials Give consent after my death to an autopsy or postmortem examination of my remains: Initials Delegate health care decision-making power to another person ("Delegee") as selected by my Agent, and the Delegee shall be identified in writing by my Agent; Initials With respect to anatomical gifts of my body or any part (i.e., organs or tissues), please initial your desired choice below: **AUTHORIZATION OF ANATOMICAL GIFTS.** I wish to AUTHORIZE my Agent to make an Initials anatomical gift of my body or part (organ or tissue). My donations are for the following purposes: (check one) GIFT SPECIFICATIONS: (check one) ☐ Transplantation I would like to donate □ Therapy ☐ Any needed organs and tissues, as allowed by law. □ Research ☐ Any needed organs and tissues as allowed by law, □ Education with the following restrictions: \square All the above **PROHIBITION OF ANATOMICAL GIFTS.** I DO NOT AUTHORIZE my Agent to make an anatomical gift of my body or any part (organ or tissue). Initials 7. Agent's Financial Liability and Compensation. My Agent, acting under this Durable Power of Attorney for Health Care, will incur no personal financial liability. My Agent shall not be entitled to compensation for services performed under this Durable Power of Attorney for Health Care, but my Agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions hereof. PART II. HEALTH CARE DIRECTIVE (If you DO NOT WISH to make a health care directive but only wish to have an Agent make your decisions without the directive, be sure that you have completed Part I on pages 1 & 2, mark an "X" through Part II on pages 2 & 3 and continue to Part III.) 1. I make this HEALTH CARE DIRECTIVE ("Directive") to exercise my right to determine the course of my health care and to provide clear and convincing proof of my choices and instructions about my treatment. Parts I & II - The Missouri Bar Form Detachable Insert Initials Page 2 of 4 Durable Power of Attorney for Health Care and/or Health Care Directive Revised 2/14

	ninal illn	-		on of my recovery from a seriously incapacitating ocedures that I have initialed below be withheld or			
	nitials	artificially supplied nutrition and hydratic	on (includi	ng tube feeding of food and water)			
	nitials	surgery or other invasive procedures	Initials	heart-lung resuscitation (CPR)			
ī	nitials	antibiotics	Initials	dialysis			
ī	nitials	mechanical ventilator (respirator)	Initials	chemotherapy			
	nitials	radiation therapy					
ī	nitials	other procedures specified by me (insert)					
Ī	nitials	all other "life-prolonging" medical or surg without reasonable hope of improving my		dures that are merely intended to keep me alive or curing my illness or injury			
of time also did also	e. If it derect that ppress in I have a con of my or tissue AVE NO	obes not cause my condition to improve, I direct I be given medical treatment to relieve pain or my appetite or my breathing, or be habit-forming already consented to be on the Missouri organ or organs or tissues, I realize it may be necessaries can be removed.	t the treatment to provide and tissue of the maintal transfer of the treatment of the treat	OWER OF ATTORNEY, PART II OF THIS AS MY HEALTH CARE DIRECTIVE. IN THE DURABLE POWER OF			
		hip Between Durable Power of Attorney for le Power of Attorney for Health Care and Hea		re and Health Care Directive. If I have executed rective, I encourage my Agent to:			
	First,	follow my choices as expressed in the above D	Directive or	otherwise from knowing me or having had			
В.	various discussions with me about making decisions regarding life-prolonging procedures. Second, if my Agent does not know my choices for the specific decision at hand, but my Agent has evidence of my preferences, my Agent can determine how I would decide. My Agent should consider my values, religious beliefs, past decisions, and past statements. The aim is to choose as I would choose, even if it is not what my Agent would choose for himself or herself.						
Initials _.		Parts II & III - The Missouri Bar Form Detacha Durable Power of Attorney for Health Care and		Page 3 of 4 re Directive Revised 9/11			

- C. Third, if my Agent has little or no knowledge of choices I would make, then my Agent and the physicians will have to make a decision based on what a reasonable person in the same situation would decide. I have confidence in my Agent's ability to make decisions in my best interest if my Agent does not have enough information to follow my preferences.
- D. Finally, if the Durable Power of Attorney for Health Care is determined to be ineffective, or if my Agent is not able to serve, the Health Care Directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.
- **2. Protection of Third Parties Who Rely on My Agent.** No person who relies in good faith upon any representations by my Agent or Alternate Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.
- **3. Revocation of Prior Durable Power of Attorney for Health Care or Health Care Directive.** I revoke any prior living will, declaration or health care directive executed by me. If I have appointed an Agent in a prior durable power of attorney, I revoke any prior health care durable power of attorney or any health care terms contained in that other durable power of attorney and intend that this Durable Power for Attorney for Health Care (if completed) and this Health Care Directive (if completed) replace or supplant earlier documents or provisions of earlier documents.
- **4. Validity.** This document is intended to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be as valid as the original.

IF YOU HAVE COMPLETED THE ENTIRE DOCUMENT OR ONLY THE DIRECTIVE (PART II), YOU MUST SIGN THIS DOCUMENT IN THE PRESENCE OF TWO WITNESSES.

IN WITNESS WHEREOF, I signed this documen	t on	(month, date),	(year).
	Signature Printed Name: _		
WITNESSES: The person who signed this docume presence. Each of the undersigned witnesses is at least		luntarily signed this	document in our
Signature	Signature		
Print Name	Print Name		
Address	Address		
STATE OF MISSOURI) (Omy required if Ya STATE OF MISSOURI) (SS) COUNTY OF)	rt I or entire document comp	ieteu.)	
On this day of (month),, to me known to be the person described in executed the same as his/her free act and deed.	(year), before me persona n and who executed the foregoin	ally appeared ng instrument and ack	nowledged that he/she
IN WITNESS WHEREOF, I have hereunto set my hand aforementioned, on the day and year first above written.	d and affixed my official seal in	n the County or City ar	nd state
	(Name Pr		, Notary Public
Part III - The Missouri Bar Form Deta Durable Power of Attorney for Health		;	Page 4 of 4 Revised 9/11