Durable Health Care Power of Attorney

I, ofCounty, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.				
Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104—191, 110 Stat. 1936), the regulations promulgated thereunder and any other State or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.				
The remainder of this document will take effect when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My health care agent may not delegate the authority to make decisions.				
My health care agent has all of the following powers subject to the health care treatment instructions that follow in Part III (cross out any powers you do not want to give your health care agent):				
1.	To authorize, withhold or withdraw medical care and surgical procedures.			
2.	To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.			
3.	To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.			
4.	To hire and fire medical, social service and other support personnel responsible for my care.			
5.	To take any legal action necessary to do what I have directed.			
6.	To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.			
Appointment of Health Care Agent				
I appoint the following	ng health care agent:			
Health Care	Agent (Name and relationship):			
Address:				
Telephone Number: HomeWork				

E-Mail:

If you do not name a health care agent, health care providers will ask your family or an adult who knows your preferences and values for help in determining your wishes for treatment. Note that you may not appoint your doctor or other health care provider as your health care agent unless related to you by blood, marriage or adoption.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative health care agents.)

Telephone Numbers: Home	Work
E-Mail:	
Second Alternative Health Care Agent (name	e and relationship):
Address:	
Telephone Number: Home	Work
E-Mail:	
Guidance for Hea	Ith Care Agent (optional) Goals
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cal decisions are as follows (insert your personal	reme irreversible medical condition, my goals in making priorities such as comfort, care, preservation of mental

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

Initials	l agree
Initials	I disagree

Health Care Agent's Use of Instructions (Initial one option only)

	My health care agent must follow these instructions.
	OR
	These instructions are only guidance. My health care agent shall have final say and may override any of my instructions. (Indicate any exceptions)
If I did not ap	ppoint a health care agent, these instructions shall be followed.
	Legal Protection
actions in foll behalf of myso and indemnif	law protects my health care agent and health care providers from any legal liability for their good faith owing my wishes as expressed in this form or in complying with my health care agent's direction. On elf, my executors and heirs, I further hold my health care agent and my health care providers harmless by them against any claim for their good faith actions in recognizing my health care agent's authority or my treatment instructions.
	Organ Donation (Inital one option only.)
	I consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. (Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.)
	OR
	I do not consent to donate my organs or tissues at the time of my death.
	Signature
Having carefu	ılly read this document, I have signed it this day of
reatment inst	, 20 , revoking all previous health care powers of attorney and health care cructions.
Ü	ne here for health care power of attorney and health care treatment instructions.)
witness:_	
WITNESS:	

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each
other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a
witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health
care providers.)

Notarization (optional) (Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.)				
In witness whereof, I have hereunto set my hand and affixed, State of				
Notary Public	My commission expires			