Health Care Power of Attorney

KNOW ALL PERSONS BY THESE PRESENTS, that I, ___________________________, of Elkhart County, State of Indiana, have made, constituted and appointed, and by these presents do make, constitute and appoint:

(Name of attorney-in-fact) ____

(Address) ____

(Home Telephone) ________________________ (Work/cell telephone) _____________________

and/or:

(Name of attorney-in-fact) ____

(Address) ____

(Home telephone) ________________________ (Work/cell telephone) _____________________

as my true and lawful attorneys each with the absolute right, power and authority for me and in my name, place and stead, to act as follows, and to do any and everything that may be necessary as incident thereto, including:

To act for me and to consent for me in all matters affecting my health care whenever I am incapable of consenting to health care matters, pursuant IC 30-5-5-16,17 (the provisions of which are incorporated in their entirety herein) to include, but not be limited to, the following acts on my behalf: arrange for admission to and sign all admission documents and do all things required in connection with my admission as an inpatient or outpatient at any hospital, nursing home or health care facility and to execute consents for, or authorize withholding of, medical treatment, procedures or surgery, all on my behalf; and to execute releases of liability or other waivers or releases as to any physician, surgeon, hospital and/or employees thereof, all as my said attorney may, in my said attorney's discretion determine necessary or desirable, and with the same effect as if I personally have so acted; and

Those appointed, and each of them, are within my "circle of care" as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and I specifically hereby extend informed written permission to any and all physicians, hospitals, their staff and employees and medical care providers of any sort to disclose any and all health related information, to include but not limited to, that information defined by HIPAA as protected health information or "PHI" to my Health Care Representative herein appointed. Such disclosures may be in the form of general information and/or for the purposes of making medical recommendations about treatment alternatives, to include but not limited to the utilization or the withholding of life sustaining medications, treatments, procedures, and techniques without limitations; and

2. This power of attorney is effective immediately and shall not be affected by the subsequent disability or incapacity of the principal, or lapse of time, and the authorities conferred herein shall be exercisable by my said attorney until such time as I have executed a written revocation hereof.

I attach hereto, and incorporate herein, the appointment of my attorneys-in-fact as my health care representatives under IC 16-36-1 as follows:

Appointment of Health Care Representative

I, the principal named above, in accord with the provisions of IC 16-36-1-7, do hereby appoint my attorneys-in-fact named above as my representatives to act for me in matters affecting my health.

I authorize my Health Care Representative to arrange for admission to and sign all admission documents and do all things required in connection with my admission as an inpatient or outpatient at any hospital, nursing home or health care facility and to execute consents for medical treatment, procedures or surgery, all on my behalf, and to execute releases of liability or other waivers or releases as to any physician, surgeon, hospital and /or employees thereof;

I further authorize my Health Care Representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my Health Care Representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my Health Care Representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My Health Care Representative must try to discuss this decision with me. However, if I am unable to communicate, my Health Care Representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my Health Care Representative may also discuss this decision with my family and others to the extent they are available.

Signed this ____ day of _____________, 20___.

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STATE OF INDIANA)
) SS:
COUNTY OF ELKHART)

Before me, the undersigned, a Notary Public in and for said county and state, this ____ day of _____________, 20___, personally appeared the within named _______________________________ and acknowledged the execution of the above and foregoing Health Care Power of Attorney and Appointment of Health Care Representative for the uses and purposes therein set forth.

WITNESS my hand and Notarial Seal.

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