

MEDICAL DURABLE POWER OF ATTORNEY

I, _____, of _____
Street Address
_____, principal, hereby appoint
City, State & Zip Code
_____ to serve as my agent to make health care
decisions for me as authorized in this document.

If the person named as my agent is not available or is unable to act due to death, incapacity or resignation, I appoint the following persons in order of priority to act as successor agents:

- 1. _____
- 2. _____
(You may name successor agents or state none)

I. Effective Date and Durability. By this document, I intend to create a Medical Durable Power of Attorney which shall take effect:
(Initial your choice)

- _____ (a) immediately on signing and the authority shall not be affected by my subsequent incapacity.
- _____ (b) upon my incapacity to make my own health care decisions, as determined by my agent and attending physician, and shall continue during that incapacity.

Regardless of the effective date, it is my intention that I be consulted with regard to my health care decisions as long as I have the capacity to understand and make my own health care decisions.

II. Right to Revoke. I revoke all prior Medical Durable Powers of Attorney that I may have executed, and I retain the right to revoke or amend this document and to substitute other agents in place of those named herein. Amendments to this document shall be made in writing by me personally, and not by any agent named herein, and they shall be attached to the original of this document.

III. Relationship to Living Will. If I have executed a "Living Will" pursuant to Colorado's Medical Decision Treatment Act, C.R.S., Title 15, Article 18, I direct my agent as follows:
(Initial your choice)

- _____ (a) to follow any declaration or direction as to medical or surgical treatment as set forth in my Living Will.
- _____ (b) to make decisions based on specific instructions given to my agent, whether or not such decisions follow the declaration or direction in my Living Will.
- _____ (c) I have not signed a Living Will at this time.

IV. Agent's Powers. My agent is authorized to make health care decisions for me based on instructions stated in this Medical Durable Power of Attorney or as I make known to my agent in some other way. In making such decisions, my agent should first try to discuss with me any proposed health care treatment decisions. If I am unable to give an informed consent to a proposed health care treatment, my agent shall give, withhold, withdraw or modify such consent for me based upon any treatment choices that I have expressed while competent, whether under this document or otherwise. If my agent can not determine the treatment choice I would want made under the circumstances, then my agent should make the decision for me based upon what my agent believes to be in my best interest. By way of illustration and not as a limitation, my agent is authorized as follows:



A. Medical Records, HIPAA Release Authority and Admissions to Health Care Facilities. My agent may have access to all of my medical information and records; may disclose medical and related information concerning my treatment to appropriate persons or entities; may admit or transfer me to such hospitals, hospices, or treatment facilities as my agent deems to be in my best interests; and may retain and discharge physicians and other medical advisors. I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 42 U.S.C. 1320d and 45 C.F.R. 160-164. I authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau, Inc. or other healthcare clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services to give, disclose, and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse. The authority given to my agent shall supercede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

B. Employ and Discharge Health Care Personnel. My agent may employ and discharge medical personnel including, but not limited to, physicians, psychiatrists, dentists, nurses, and therapists as my agent shall deem necessary for my physical, mental and emotional well-being, and to arrange for reasonable compensation.

C. Medical Consent to Treatment. My agent shall have absolute discretion to give, withhold or withdraw consent to any medical procedures, tests or treatments, including surgery. My agent may arrange and contract for hospitalization, convalescent care, hospice or home care as I may require. Under those circumstances in which my agent determines that certain medical procedures, tests or treatments are no longer of any benefit to me or, where the benefits are outweighed by the burdens imposed, my agent may, in my agent’s sole discretion, but after making every effort to communicate with me first, revoke, withdraw, modify or change consent to such procedures, tests and treatments, as well as hospitalization, convalescent care, hospice or home care, which I or my agent may have previously allowed or consented to or which may have been implied due to emergency conditions.

D. Authorize Relief From Pain. My agent may authorize and consent to the administration of pain relieving drugs of any kind or other surgical or medical procedures calculated to relieve my pain, including unconventional pain-relief therapies which my agent believes may be helpful, even though such drugs or procedures may have adverse side effects, may cause addiction or may hasten the moment of (but not intentionally cause) my death.

E. Grant Releases. My agent is authorized to grant any releases to hospital staff, physicians, nurses or other medical and hospital administrative personnel who act in reliance on instructions given by my agent in connection with any matter described in this document. Any document may be signed by my agent which has the effect of implementing my wishes regarding health care treatment or withholding of treatment.

F. Provisions for Residence and Transportation. All necessary arrangements may be made for me by my agent for any hospital, hospice, nursing home, convalescent home or similar establishment to assure that all of my essential needs are provided for at such a facility. My agent may execute any contract on my behalf to make residential arrangements without my agent incurring personal financial liability for such contracts. Transportation to and from any residential or health care treatment facility may be made by my agent including emergency transportation services.

G. Anatomical Gifts. (Optional) My agent may, as indicated by my signature below, make anatomical gifts which will take effect at my death to such persons and organizations as my agent shall deem appropriate and may execute such papers and do such acts as shall be necessary, appropriate, incidental or convenient in connection such gifts.

I hereby make an anatomical gift, to be effective upon my death, of:
(Initial your choice)

- _____ (a) Any needed organs/tissues
- _____ (b) The following organs/tissues:

Donor Signature

H. Surrogate Decision-maker for Health Care Benefits. My agent is authorized to act on my behalf in making health care benefit decisions for public or private benefits programs and to file any necessary appeals on my behalf. Health care benefit decisions shall mean any decision or action related to the application, enrollment, disenrollment, appeal, or other function necessary for private or public health care benefits that do not conflict with any preference I have expressed to my agent, either orally or in writing. I am expressly appointing my agent as my surrogate for decision-making for health care benefits as contemplated in Colorado Revised Statutes 15-14-505 and 15-18.5-101 *et. seq.*

V. Specific Instructions or Limitations.

A. If I am in a terminal condition that is reasonably expected to result in my death within twelve (12) months, regardless of treatment, and I am unable to make decisions about my health care treatment, it is my direction that:

B. If I am in a persistent vegetative state, referring to a permanent loss of consciousness from which there is no reasonable possibility that I will return to a cognitive conscious state, it is my direction that:

C. If my agent has directed that life-sustaining procedures be withheld or withdrawn, with the exception of procedures to keep me comfortable and alleviate pain, I direct that artificial nutrition and hydration be:
(Initial your choice)

- _____ (a) continued until my death.
- _____ (b) withheld or withdrawn.
- _____ (c) (other) _____
- _____
- _____

D. Specific other instructions or limitations:

VI. Third Party Reliance. No person, facility, institution or other entity who relies in good faith upon the authority of my agent under this document shall incur any liability to me, my estate, my heirs, successors or assigns. Anyone who relies in good faith on the instruction of my agent shall be held harmless as a result of such reliance regardless of any unknown revocation or amendment of this document.

VII. Immunity for My Agent. My agent and my agent's estate, heirs, successors and assigns are hereby released and forever discharged by me, my estate, my heirs, successors and assigns from all liability and from all claims arising out of the acts or omissions of my agent, except for willful misconduct or gross negligence.

VIII. Resort to Courts. My agent is authorized to seek on my behalf and at my expense, only if necessary:

- A. a declaratory judgment, from a court of competent jurisdiction, regarding the validity of this document or the authority granted to my agent under this document.
- B. appointment of a guardian to act on my behalf. I nominate my agent to serve in the capacity of guardian if the court finds that appointment of a guardian is necessary.
- C. actual and punitive damages against any party who in bad faith fails to comply with the instructions of this document or my agent, thus necessitating the commencement of a court proceeding.

IX. Governing Law and Interstate Application. This document shall be governed by the laws of the State of Colorado and specifically the "Colorado Patient Autonomy Act" in Sections 15-14-503 to 15-14-509, C.R.S. I intend that this Medical Durable Power of Attorney, duly executed according to the laws of Colorado, be recognized to the fullest extent possible by any health care facility or court of any other state.

I execute this Medical Durable Power of Attorney on _____ (date)
at _____.

Principal

STATE OF COLORADO

COUNTY OF _____

} ss.

I, _____, a Notary Public in and for the County and State aforesaid do hereby certify that _____ personally known to me to be the principal whose name is subscribed to the foregoing Medical Durable Power of Attorney, appeared before me this day in person and acknowledged that the principal signed the instrument of writing as the principal's free and voluntary act, and for the uses and purposes therein set forth.

WITNESS my hand and official seal.

Notary Public

My commission expires: _____

WITNESSES: I declare that the principal who signed or acknowledged this document is personally known to me, that the principal signed or acknowledged this Medical Durable Power of Attorney in my presence, and that the principal appears to be of sound mind and under no duress, fraud or undue influence. I am not the person appointed as the agent by this document, nor am I the patient's health care provider, or an employee of the patient's health care provider.

Signature of Witness

Signature of Witness

Home Address

Home Address

Phone No.

Phone No.

Date

Date