**APPOINTMENT OF HEALTH CARE AGENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, whose address is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby appoint the following person to act as my agent to make health care decisions for me:

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Telephone: \_\_\_-\_\_\_-\_\_\_\_\_

If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I hereby appoint the following person, individually and in the following order, to act as my agent to make health care decisions for me:

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Telephone: \_\_\_-\_\_\_-\_\_\_\_\_

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Telephone: \_\_\_-\_\_\_-\_\_\_\_\_

2. My agent has full power and authority to make health care decisions for me, including the power to:

1. Request, receive, and review any information oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and consent to disclosure of this information;
2. Employ or discharge my health care providers;
3. Authorize my admission to or discharge from (including transfer to another facility) any hospital , hospice, nursing home, adult home or other medical care facility; and
4. Consent to the provision, withholding or withdrawal of health care including, in appropriate circumstances, life-sustaining procedures.

3. I, authorize any health care provider to release my complete medical records (including medical information related to my diagnosis or treatment] to my agent. I understand I may inspect or receive copies of the information to be used or disclosed, as a provider in CFR164.524.

 By signing below, I indicate that I am emotionally and mentally competent to make this appointment of a health care agent and that I understand the purpose and effect.

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

Date (your name)

 The declarant signed or acknowledge signing this appointment of a health care agent in my presence and based upon my personal observation appears to be competent individual.

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

Witness Witness

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Address Address