POWER OF ATTORNEY FOR HEALTH CARE by _____	*	UNITED STATES OF AMERICA STATE OF LOUISIANA PARISH OF _____ CITY OF _____

* *

BE IT KNOWN, that on this ____ day of the month of _____, in the year two thousand _____,

BEFORE ME, the undersigned Notary Public, duly commissioned and qualified in and for the Parish and State aforesaid, in the presence of the witnesses hereinafter named and undersigned,

PERSONALLY CAME AND APPEARED:

_____,

A person of the full age of majority, and a resident of the Parish of **_____,** State of Louisiana, hereinafter sometimes referred to as "Appearer", appearing herein for the purpose of granting a power of attorney for health care, as follows:

A. **Designation of Health Care Agents.** I reside at **_____ _____.** My **home/cell** telephone number is **(_____) _____-_____.** I name the following individuals as my Health Care Agents, with ***each of them having full power to act without the concurrence of any of the others.*** All of these individuals are collectively referred to as my "Agent". In the event of a disagreement among the individuals named herein as Health Care Agents relative to action to be taken herein, the decision of _____ shall be determinative and final.

1. **First** Health Care Agent: _____
   Address: _____
   Cell Phone: **(_____) _____-_____**
   Home Phone: **(_____) _____-_____**
   Work Phone: **(_____) _____-_____**

2. **Second** Health Care Agent: _____
Address: _____
Cell Phone: (_____) _____-_____
Home Phone: (_____) _____-_____
Work Phone: (_____) _____-_____

3. **Third** Health Care Agent: _____
Address: _____
Cell Phone: (_____) _____-_____
Home Phone: (_____) _____-_____
Work Phone: (_____) _____-_____

4. **Fourth** Health Care Agent: _____
Address: _____
Cell Phone: (_____) _____-_____
Home Phone: (_____) _____-_____
Work Phone: (_____) _____-_____

B. **Effective Date.** By this document I intend to create a durable power of attorney effective upon, and only during, any period of incapacity in which, in the opinion of my Agent and attending physician, I am unable to make or communicate a choice regarding a particular health care decision. If I am a "qualified patient" as defined in Section 1299.58.2(8) of Title 40 of the Louisiana Revised Statutes or any amendment or replacement thereof or similar statute of another jurisdiction and I have executed a Declaration Relative to Life-Sustaining Procedures ["Living Will"] then such Declaration shall prevail to the extent that it is not inconsistent herewith.

C. **Agent's Powers.** My Agent shall have full authority to make decisions for me regarding my health care. In exercising this authority, my Agent shall follow my desires as stated in this document, my Living Will, or otherwise known to my Agent. Prior to making any decision, my Agent shall attempt to determine my desires. If I am unable to communicate in any way and my Agent cannot determine the choice I would want made, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interests. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

1. Accordingly, unless specifically limited by Section 2 below, my Agent is authorized as follows:

   a. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic

procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

b. To have access to my medical records and information, including health information and protected health information as defined by the Health Insurance Reportability and Accountability Act of 1996 (HIPAA), and regulations adopted pursuant thereto, to the same extent that I am entitled to, including the right to disclose the contents to others;

c. To authorize my admission to or discharge from (even against medical advice) any hospital, nursing home, residential care, assisted living, or similar facility or service;

d. To contract on my behalf for any health care related service or facility on my behalf, without my Agent incurring personal financial liability for such contracts;

e. To hire and fire medical, social service, and other support personnel responsible for my care;

f. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death;

g. To 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 hospital, physician, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my Agent, or to seek damages for the failure to comply.

2. **Statement of Desires, Special Provisions, and Limitations.**

a. **Life Sustaining Procedures.** With respect to any "life-sustaining procedures", I have made provisions in a **separate Living Will, dated even date herewith,** and I direct that my Agent follow the directions provided therein.

b. **Diagnostic Tests.**

_____ I do not wish to have diagnostic tests performed on me unless they are clearly related to making me well.

_____ I wish to have any diagnostic tests performed that both my Agent and my attending physician deem necessary.

c. **Experimental Treatment and/or Surgery.**

_____ I am aware of the risks involved with unknown, aggressive medical treatments, and I direct my Agent to consent to any experimental treatment or surgical procedure which may improve my condition.

_____ I do not wish to undertake treatments or undergo surgeries which have not been shown to offer meaningful, measurable results. I recognize that by refusing such treatment I may be significantly decreasing my life expectancy or eliminating the possibility of my recovery.

d. **Blood Transfusions.**

_____ I authorize any blood transfusions deemed necessary by my physician to restore me to health or improve my condition. I am aware of the risks associated with blood transfusions, including, but not limited to contracting blood-borne diseases such as AIDS or hepatitis, and, if possible, I would like to be transfused with my own blood or blood from a known donor.

_____ I understand the risks involved with withholding transfusions, including potentially hastening death, but, for religious reasons or otherwise, I do not consent to any blood transfusions.

e. **Organ Donation.**

_____ I do not want to make an organ or tissue donation and I do not want my Agent or family to do so.

_____ Pursuant to Louisiana law, I hereby give, effective upon my death,

_____ any needed organ, tissue or parts
_____ the following part or organs listed:
_____
_____
for
_____ any legally authorized purpose.
_____ transplant or therapeutic purposes only.
_____ research or education only.

f. **Amputation.**

_____ I understand the risks involved with amputating a limb and authorize my Agent to consent on my behalf to any such amputation which will significantly improve my medical condition.

_____ I do not consent to any amputation. I understand the risks involved with refusing to allow such an operation, including infection and bodily deformation, and choose to seek other treatments, even if they are significantly less likely to improve my life.

g. **Cardiopulmonary Resuscitation.**

_____ If my heart has stopped beating and there is no reasonable expectation of my recovery, I consent to a physician's Do Not Resuscitate order.

_____ If my heart has stopped beating, I wish to employ all means of medical treatment which will restore me to life.

h. **Pain Relief.**

_____ If I am in pain or significant discomfort, I want to be given appropriate medication to relieve such pain. In the event that I am in severe pain, I wish to receive sufficient medication to ease my discomfort, even if such dosages may shorten my expected life span.

_____ I do not wish to receive medication to relieve pain caused by terminal illness or any other debilitating disease. I understand that such wish may significantly affect my comfort and cause unnecessary suffering on my part, but, nevertheless, withhold consent.

i. **Clinical Trials.**

_____ I am willing to participate in clinical trials.
_____ I do not consent to any participation in clinical trials.
_____ My Agent may give consent or refuse to allow participation in clinical trials.

j. **Psychotropic Medications.**

_____ I do not wish to receive psychotropic medications unless, in the opinion of my Agent, such administration is necessary to preserve my life.

_____ If I am diagnosed as having a psychoneurotic disorder, I am willing to be administered such psychotropic medications as my attending physician recommends.

k. **Electroconvulsive Treatments.**

_____ I do not wish to receive electroconvulsive treatment.

_____ I am willing to accept such electroconvulsive treatment as my attending physician recommends.

l. **Pacemaker/Defibrillator.**

_____ My Agent is authorized to order the disabling of any pacemaker/defibrillator that may have been installed in my body.

m. **Autopsy.**

_____ I do not consent to an autopsy.
_____ I consent to an autopsy.
_____ My Agent may give consent or refuse an autopsy.

3. **Protection and Third Parties Who Rely on my Agent.** No person who relies in good faith upon any representations by my Agent or Successor Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

4. **Administrative Provisions.**

a. I revoke any prior power of attorney for health care.

b. This power of attorney is intended to be valid in any jurisdiction in which it is presented. A copy of this power of attorney is intended to have the same effect as the original.

c. My Agent shall be entitled to receive from any of my medical providers any privileged information, including information which is privileged under the HIPAA Regulations.

d. My Agent shall not be entitled to compensation for services performed under this power of attorney, but my Agent shall be entitled to reimbursement for all reasonable expenses as a result of carrying out any provision of this power of attorney.

e. The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect any others.

f. This health care power of attorney is revocable in whole or in part by me. If I so choose, I can verbally, physically, or in writing, cancel this directive.

THUS DONE AND PASSED in the City of _____, State of Louisiana, on the day, month and year hereinabove first written, in the presence of the undersigned competent witnesses who have hereunto signed their names, together with the said Appearer and me, Notary, after due reading of the whole.

WITNESSES:

_____ _____

Printed Name:_____ Printed Name:_____

_____

Printed Name:_____

_____

Printed Name:_____, LSBA No. _____

Notary Public for the

Parish of _____, State of Louisiana,

and Attorney at Law.

My commission is for life.