Name:_____
Date of Birth:_____

POWER OF ATTORNEY FOR HEALTH CARE

1. I, _____, **[patient's name]** appoint _____, **[person appointed]** whose contact information is as follows: _____, **[address and phone number]** as my attorney in fact for health care. I authorize my attorney in fact appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions. I declare this Power of Attorney for Health Care to be a durable Power of Attorney, which shall not be affected by my disability or incapacity, and the authority granted herein shall continue during any period while I am disabled or incapacitated. I have read the warning at Paragraph 8 of this document and understand the consequences of executing a power of attorney for health care.

(a) In the event _____**[1st attorney in fact]** is unwilling or unable to act as my attorney in fact under this power for any reason whatsoever, I do hereby appoint _____ _____ **[alternate #1]** whose contact information is as follows:_____ _____ , as my successor attorney in fact, to have the full right to exercise all powers given herein. If neither _____**[1st attorney in fact]** nor _____**[alternate #1]** is able to act as my attorney in fact, I then appoint_____ **[alternate #2],** whose contact information is as follows:_____ _____ as the successor attorney in fact under this Power of Attorney for Health Care.

2. Subject to any limitations in this document, my attorney in fact has the authority to make health care decisions for me of any kind or nature, including any decisions regarding my physical or mental health. This power shall include, but not be limited to, the following that I have initialed:

(a) _____ All powers of attorney for healthcare including the powers set forth in (b)-(l) below **[if initialed unnecessary to initial (b)-(l)]**;

(b) _____The power to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996,

Pub. L. No. 104-191, and the regulations in 45 C.F.R. Sec. 160, et. seq., and any other applicable federal, state or local laws or regulations, (collectively "HIPAA"), including the power to request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records, and any information or protected private records of any kind, or otherwise covered under HIPAA. I authorize my attorney in fact to execute on my behalf any documents that may be required to obtain this information, and to otherwise consent to the disclosure of this information;

(c) _____The power to establish my residence, including any power concerning my care in a nursing home or other such facility;

(d) _____The power to select, employ and discharge physicians or other health care personnel;

(e) _____The power to act as my Support Person, whether one or more, as defined by the Department of Health and Human Services for purposes of exercising my patient visitation rights or to designate on my behalf another individual or individuals to act as my Support Person or Support Persons;

(f) _____The power to admit me to any hospital or other such institution for any purpose whatsoever, as determined by my attorney in fact, and to arrange for my hospitalization, convalescent care, hospice or other care;

(g) _____The power to give or withhold consents to medical or psychiatric treatment of any kind or nature, including medical procedures, tests or treatments, including surgery, and releases to medical personnel and others;

(h) _____The power to authorize relief from pain;

(i) _____The power to take all actions that a guardian or conservator could take under Nebraska law; and

(j) _____The power to make, make known, implement and enforce all health care decisions which I could make if I had the capacity or were competent, including decisions to choose among alternative care and therapies, to exercise or waive any privilege I may have with respect to confidential, hospital and medical information and records about my diagnosis, condition and care.

LIVING WILL

(k) _____I direct that my attorney in fact comply with the following instructions on life-sustaining treatment, and artificially administered nutrition and hydration: If at any time I am incapable of making health care decisions and I am suffering from a terminal condition, or am in a persistent vegetative state, I direct that my attorney in fact shall have the authority to consent to the withholding or withdrawing of life-sustaining procedures which would serve only to prolong the dying process, so that I may be permitted to die naturally with only the performance of any routine care necessary to maintain my comfort or to alleviate pain. In addition, I direct that my attorney in fact shall have the authority to consent to the withholding or withdrawing of artificially administered nutrition or hydration, so that I may be permitted to die naturally with only the performance of any routine care necessary to maintain my comfort or to alleviate pain.

(l) _____[**initial if have or want a living will**] I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my attorney in fact believes the burdens of the treatment outweigh the expected benefits. I want my attorney-in-fact to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment. This grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including the withdrawal of food and water and other life-sustaining measures, if my agent believes such action would be consistent with my intent and desires.

3. Where necessary to implement the health care decisions that my attorney in fact is authorized by this document to make, my attorney in fact has the authority to execute on my behalf any of the following:

(a) Documents titled or purported to be a "consent to permit treatment", "refusal to permit treatment", or "leaving hospital against medical advice".

(b) A waiver or release from liability required by a hospital, physician or health care provider.

4. I direct that my attorney in fact comply with the following instructions or limitations: My attorney in fact shall base health care decisions on my health care choices that I have expressed prior to the time of the decisions. If I have not expressed health care choices about the matter in question, my attorney in fact shall base health care decisions on what he or she believes to be in my best interests.

5. The opinion of my attending physician shall be conclusive proof that I do not have the capacity to make health care decisions, am suffering from a terminal condition or am in a persistent vegetative state for purposes of this document.

6. I hereby revoke any and all Powers of Attorney for Health Care I have previously made.

7. In addition, if any powers are exercised by my attorney in fact under this Power of Attorney for Health Care, I direct that he/she notify all of my other **(named attorney in fact /children/child)** of the actions taken pursuant to this Power of Attorney for Health Care within a reasonable time after the actions are taken.

8. I HAVE READ THIS POWER OF ATTORNEY FOR HEALTH CARE. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY ATTORNEY IN FACT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

Dated this _____ day of _____, 20____.

_____

_____, Principal

DECLARATION OF WITNESSES

We declare that the Principal is personally known to us, that the Principal signed or acknowledged **his/her** signature on this Power of Attorney for Health Care in our presence on the date of notarization, that the Principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the Principal's attending physician is the person appointed as attorney in fact by this document.

Witnessed By:

_____ _____

Name:_____
Date of Birth:_____

This form also needs to be notarized. Document this signature on next page.

STATE OF NEBRASKA)
) ss.
COUNTY OF MADISON)

On this _____ day of _____, 20 __, before me, a notary public in and for this county, personally came _____, [**insert patient's name**] personally known to me to be the identical person whose name is affixed to the above Power of Attorney for Health Care as Principal, and I declare that **he/she** appears of sound mind and not under duress or undue influence, that **he/she** acknowledges the execution of same to be **his/her** voluntary act and deed, and that I am not the attorney in fact or successor attorney in fact designated by this Power of Attorney for Health Care.

Witness my hand and notarial seal in such county the day and year last above written.

_____
Notary Public