DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS DECISION TO NAME SOMEONE TO SPEAK FOR ME _ , appoint the following person(s) to (date of birth) make healthcare decisions for me when I am unable to make or communicate my own wishes: Agent may not be the treating healthcare provider, an employee of the treating healthcare provider, or an employee, owner, director or officer of a facility, unless that person is a relative or is bound to you by common vows to a religious life. PLEASE PRINT: Name of Agent: Telephone Agent's address: State/Zip ___ Name of First Alternate Agent: _ Telephone Telephone _City_ Agent's address: _ _State/Zip ___ Name of Second Alternate Agent: _ Telephone Telephone Agent's address: _ _City_ _State/Zip _ This power of attorney for healthcare decisions shall become effective when I am unable to make decisions or unable to communicate my wishes regarding healthcare. This power of attorney for healthcare decisions shall not be affected by my subsequent disability or incapacity. Any durable power of attorney for healthcare decisions I have previously made is hereby revoked. **AUTHORITY GRANTED** My agent shall authorize consent for the following special My healthcare agent may: instructions: 1. Consent, refuse consent, or withdraw consent to any care, \square I wish to be a donor for organs and tissues. treatment, service or procedure to maintain, diagnose or ☐ I have attached information about treatment choices I wish treat a physical or mental condition; to have honored by my agent. ____ page(s) attached. 2. Make all arrangements for me at any hospital, treatment facility, hospice, nursing home or similar institution; 3. Employ or discharge healthcare personnel including physi-LIMITATIONS ON AUTHORITY GRANTED cians, psychiatrists, dentists, nurses, therapists or other My healthcare agent may not: persons who provide treatment for me; 1. Exceed the powers set out in writing in this document; or 4. Request, receive and review any information, spoken or 2. Revoke any existing Living Will Declaration I may have. written, regarding my personal affairs or physical or mental health including medical and hospital records, and execute any releases or other documents that may be required in order to obtain such information; and 5. Make decisions about organ and tissue donations, autopsy and the disposition of my body. Notary Seal: **Notary Public:** COUNTY OF ___ This instrument was acknowledged before me this ______ day of _____ (month, year) Signature of Notary__ or Witnesses: (witnesses may not be the agent or a relative, or beneficiary of the principal)



(Signature)

(Signature)

This document is based on Kansas Statutes Annotated, (58-625 through 632) Additional forms and information are available through

Date:

Date: