POWER OF ATTORNEY FOR HEALTHCARE FORM

NOTICE: PLEASE READ CAREFULLY.

This form is a legal document governed by the Illinois Power of Attorney Act. If there is anything that you do not understand about this document, you should ask your lawyer to explain it to you.

The purpose of a Power of Attorney is to give the person you designate as your Agent broad powers to make healthcare decisions for you when you are unable to do so. The Agent's powers include consent to, or withdrawal of treatment for any physical or mental condition, and to admit you or discharge you from any hospital, home or other institution. You may name successor agents under this form, but you may not name co-agents.

This form does not impose a duty upon your Agent to make healthcare decisions, so it is important that you select an agent who will agree to do this for you and who will make those decisions as you would wish. Select an agent you trust, since you are giving that agent control over your medical decision-making, including end-of-life decisions. Your Agent has a duty to act for your benefit. He or she must also act in accordance with the law and with the direction in this form. Your Agent must keep a record of all significant actions taken as your agent.

Unless you specifically limit the period of time this Power of Attorney for Healthcare will be in effect, your Agent may exercise the powers given to him or her throughout your lifetime, even after you become disabled or die. A court, however, can take away the powers of your Agent if it finds that the agent is not acting properly.

You may also revoke this Power of Attorney if you wish. The Powers you give your Agent, your right to revoke those powers, and the penalties for violating the law are explained more fully in Sections 4-5, 4-6 and 4-10(b) of the Illinois Power of Attorney Act. You are not required to sign the Power of Attorney. You should not sign it if you do not understand everything in it, and what your Agent will be able to do if you do sign it. Please put your initials on the following line indicating that you have read this notice.

____
Principal's (Patient's) Initials

1. APPOINTMENT OF AGENT

I, ______________________________________ [Full Legal Name], being of sound mind and over the age of eighteen (18) hereby revoke all prior powers of attorney for healthcare executed by me. I state that I currently reside at:____[Street] in the City of ________________, State of Illinois and that I appoint as my healthcare attorney-in-fact (my "agent") to act for me and in my name (in any way) I could act in person, to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and healthcare, and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue:

____ [Name of Agent]

____ [Address of Agent]

____ [Telephone # of Agent]

2. SUCCESSOR AGENTS

I understand that pursuant to Illinois law *only one person at a time may serve as my agent*. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I appoint each individual, to act alone and successively, in the order named as agent and successors to such agent:

Name: ____

Address: ____

Telephone: _________________ [work] _______________ [home]

_________________ [cell] _______________ [other]

Name: ____

Address: ____

Telephone: _________________ [work] _______________ [home]

_________________ [cell] _______________ [other]

For purposes of this paragraph, a person shall be considered to be incompetent if and while the person is a minor, or an adjudicated incompetent, or disabled person, or the person is unable to give prompt and intelligent consideration to healthcare matters, as certified by a licensed physician.

3. AGENTS GENERAL POWERS

This Power of Attorney for Healthcare authorizes my agent to make any and all healthcare decisions on my behalf, as principal, which I could make if present and under no disability. The general powers are subject to any limitations on the granted powers that appear on the face of the form, to be exercised in such manner as my agent deems consistent with my intent and desires. My agent will be under no duty to exercise granted powers or to assume control of or responsibility for my healthcare; but when granted powers are exercised, my agent will be required to use due care to act for the benefit of me, the principal, in accordance with the terms of the statutory healthcare power and will be liable for negligent exercise. My agent may act in person or through others reasonably employed by my agent for that purpose, but may not delegate authority to make healthcare decisions. My agent may sign and deliver all instruments, negotiate and enter into all agreements and do all other acts reasonably necessary to implement the exercise of the powers granted to my agent.

My agent shall have the following general powers:

(A) My agent is authorized to give consent to and authorize or refuse, or to withhold or withdraw consent to, any and all types of medical care, treatment or procedures relating to the physical or mental health of the principal, including any medication program, surgical procedures, life-sustaining treatment or provision of food and fluids for the principal.

(B) My agent is authorized to admit me, or to discharge me from any and all types of hospitals, institutions, homes, residential or nursing facilities, treatment centers and other healthcare institutions providing personal care or treatment for any type of physical or mental condition. My agent shall have the same right to visit me, the principal, in the hospital or other institution as is granted to a spouse or adult child of the principal, any rule of the institution to the contrary not withstanding.

(C) My agent is authorized to contract for any and all types of healthcare services and facilities in the name of and on behalf of me, the principal, and to bind me to pay for all such services and facilities, and to have and exercise those powers over the principal's property as are authorized under the statutory property power, to the extent the agent deems necessary to pay healthcare costs; and the agent shall not be personally liable for any services or care contracted for on behalf of me, the principal.

Unless I limit the powers in writing in this document.

4. AGENTS ACCESS TO MEDICAL RECORDS

My agent shall have access to my medical records (must select one):

______ Initials — Beginning when I sign this HPOA and continuing until I revoke this provision in writing. I must deliver a copy of the revocation to the healthcare facility where the records are located.

______ Initials — Whenever my physician documents in my medical chart that I lack decisional capacity and terminates when I regain decisional capacity.

I intend for the person named as 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 or other medical records, including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act

This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and related regulations. I intend for my agent to serve as my "personal representative" as that term is defined under HIPAA and related regulations. My agent shall have the power to authorize the release of information governed by HIPAA to third parties. I authorize: any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered healthcare provided, any insurance company and the Medical Information Bureau, Inc., or any other healthcare clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment for me for such services, to give, disclose, and release to the person named as 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, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug or alcohol abuse, and mental illness (including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act.) The authority given to the person named as my agent shall supersede any prior agreement that I may have with my healthcare providers to restrict access to, or disclosure of, my individually identifiable health information. The authority given to 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 healthcare provider. The authority given my agent to serve as my "personal representative" as defined under HIPAA and regulations thereunder, and to access my individually identifiable health information or authorize the release of the same to third parties shall take effect as defined by me at the beginning of this section.

5. EFFECTIVE DATE AND DURATION

This power of attorney shall become effective whenever my attending physician determines I lack decisional capacity and he/she documents my lack of decisional capacity in my medical record. The power of attorney shall terminate when I regain decisional capacity as determined by my attending physician and as documented in my medical chart unless I have specified another date.

If I have granted my agent the right to make decisions regarding my body, organs or remains, then this power of attorney shall remain in full force and in effect until those acts are completed, otherwise this power of attorney shall terminate upon my death.

If I want to designate an effective date or duration on my healthcare power of attorney different than what is set forth above, I understand I must specify the effective date and the termination date in the blanks below.

Effective Date: ________________ Termination Date: ________________

6. GIFT OF LIFE - ORGAN AND TISSUE DONATION [Select One]

______
Initials

I understand that my gift may save another's life and I desire to make a gift of life to another by granting my agent the authority to make the following donation:

- ☐ Any organs and tissues
- ☐ Only specific organs: ______________________________
- ☐ Tissue Only
- ☐ My body to science; I understand that I will need to execute a separate form

______
Initials

I do not grant my agent authority to make any anatomical gifts of organ or tissue.

7. ADVANCED DIRECTIVE PREFERENCE FOR END OF LIFE DECISIONS

You may choose one, if any. I state that my wishes or preferences regarding end of life, terminal condition, catastrophic brain damage and/or being in a vegetative state are as follows:

_______ Initials

I wish to die a natural death. I want to receive medical care and treatment until natural death occurs. I want to receive pain relief and comfort measures from my medical providers who are treating me. I request that my agent, in consultation with my physician, consider the burdens of the treatment and the expected benefits. I want my agent to consider the relief of suffering, the expense involved and my quality of life in making decisions concerning treatment.

_______ Initials

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless my attending physician's determines, in accordance with reasonable medical standards at the time of reference, that I am in (a) a state of permanent unconsciousness, (b) persistent or permanent vegetative state, (c) permanent or irreversible coma, (d) permanent and irreparable brain damage which would prevent me from having a quality of life, (e) terminal condition with less than six months to live as determined by my attending physician.

If any of the foregoing conditions in this section exist as documented by my attending physician, then I want life-sustaining treatment to be withheld or discontinued. For purpose of this Section, permanent unconsciousness, persistent or permanent vegetative state, permanent or irreversible coma, severe/irreparable brain damage that would prevent me from having quality of life shall mean a condition that, to a high degree of medical certainty, (i) will last permanently, without improvement, (ii) in which thought, sensation, purposeful action, social interaction, and awareness of self and environment are absent, and (iii) for which initiating or continuing life sustaining treatment, in light of my medical condition, provides only minimal medical benefit (iv) which limits my enjoyment of a meaningful quality of life.

_______ Initials

In accordance with reasonable medical standards, I want my life to be prolonged to the greatest extent possible without regard to my condition, the pain and suffering which I shall endure, the quality of my life, the chances I have for recovery or the cost of treatment and procedures to me or to my estate.

THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTHCARE, INCLUDING WITHDRAWAL OF FOOD AND WATER AND OTHER LIFE-SUSTAINING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES.

8. DO NOT RESUSCITATE ("DNR") PREFERENCE

I understand that only my physician can enter an Order for Do-Not-Resuscitate ("DNR"). A DNR is a physician's order which allows a patient to have a natural death. When a DNR is entered no cardiopulmonary resuscitation efforts are performed when death occurs. If I am an organ/ tissue donor, I may be kept on a ventilator long enough to facilitate my donation. I understand that if I undergo surgery and I have a DNR Order the DNR will be suspended while I am under anesthesia and until my anesthesiologist releases me from his/her care.

My preference regarding DNR is as follows:

________ Initials — I wish to have a natural death. Upon consultation with me or my agent, my physician may enter a DNR Order if medically appropriate. I understand that I will be afforded all treatment, care and comfort during my lifetime except that when death occurs I will not have cardiopulmonary resuscitation, which may include intravenous drugs and defibrillation (the administration of an electric shock to the heart).

________ Initials — I want to be full code. I want to receive cardiopulmonary resuscitation including intravenous drugs and defibrillation. I understand that I may be placed on a ventilator or receive other artificial means of life support. I understand that my agent may consent or my physician may terminate CPR or advanced life support when such efforts are futile. My agent may change my DNR status should my health condition significantly deteriorate per my attending physician and natural death is eminent.

________ Initials — My physician and I have executed an Illinois Statutory DNR form. A copy is attached.

9. AUTOPSY AND DISPOSITION OF REMAINS

________ Initials — My HPOA shall survive my death. I grant my agent full power to authorize an autopsy and direct the disposition of my remains. I intend for this power of attorney to be in substantial compliance with Section 10 of the Disposition of Remains Act, 755 ILCS65/1 et seq. All decisions made by my agent with respect to the disposition of my remains including cremation, shall be binding. I hereby direct any cemetery organization, business operating a crematory or columbarium (respectful place for storage of cinerary urns) or both, funeral director or embalmer, or funeral establishment who receives a copy of this document to act under it.

________ Initials — My healthcare agent shall not have power to authorize an autopsy.

10. LIMITATION ON AGENTS POWERS

I specifically restrict my Agents powers under this Healthcare Power of Attorney as follows:

______ No blood transfusion
Initials

______ Agent or subsequent Agent may not revoke my DNR Order or instruct my physician to revoke my DNR order.
Initials

______ No amputation
Initials

______ If I have terminated kidney dialysis, my agent may not revoke my decision by restarting kidney dialysis.
Initials

______ Other: ____
Initials

11. PRINCIPAL'S VERIFICATION

I am fully informed as to all the contents of this form and I understand the grant of powers to my agent.

Date: ________________ Signed: ________________________________
(Principal's signature or mark)

The principal has had an opportunity to review the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence. The undersigned witness certifies that the witness is not: (a) the attending physician or mental health service provider or relative of the physician or provider; (b) an owner, operator, or relative of an owner, operator, or relative of an owner or operator of a healthcare facility in which the principal is a patient or resident; (c) a parent, sibling, descendant, or any spouse of such parent, sibling, or descendant of either the principal or any agent or successor agent under the foregoing power of attorney, whether such relationship is by blood, marriage, or adoption; or (d) an agent or successor agent under the foregoing power of attorney. One witness required.

______________________________	______________________________
(Witness Signature)	(Witness Signature)
______________________________	______________________________
(Print Witness Name)	(Print Witness Name)
______________________________	______________________________
(Street Address)	(Street Address)
______________________________	______________________________
(City, State, Zip)	(City, State, Zip)

12. NOTARY PUBLIC SEAL (OPTIONAL)

STATE OF ILLINOIS)
) ss
COUNTY OF ST. CLAIR)

Before me, the undersigned, a Notary Public, in and for said County and State, on this _____ day of _____________, 20____, personally appeared the Principal ____________________, to me known to be the identical person who executed the foregoing instrument and acknowledged to me that he/she executed the same as his/her free and voluntary act and deed for the uses and purposes therein set forth.

Witness my hand and official seal the day and year above written.

[Seal] ______________________________Notary Public

13. AGENT AND SUCCESSOR AGENTS SIGNATURE

You may, but are not required to request your agent and successor agents to provide specimen signatures below. If you include specimen signatures in this power of attorney, you must complete the certification opposite the signatures of the agents.

I certify that the specimen signatures of my agent (a successors), agent (and successors) are correct.

____________________	____________________
(Agent)	(Principal)
____________________	____________________
(Successor Agent)	(Principal)
____________________	____________________
(Successor Agent)	(Principal)

14. PREPARER OR ATTORNEY'S SIGNATURE

If applicable, please insert the name, address and telephone number of the person preparing this form or who assisted the principal in completing this form.

____
(Name)

____
(Address)

____
(Phone)

AGENT'S CERTIFICATION AND ACCEPTANCE OF AUTHORITY FORM

I, ___________________ (insert name of agent), certify that the attached is a true copy of a power of attorney naming the undersigned as agent or successor agent for ___________________

(insert name of principal)

I certify that to the best of my knowledge the principal had the capacity to execute the power of attorney, is alive, and has not revoked the power of attorney; that my powers as agent have not been altered or terminated; and that the power of attorney remains in full force and effect.

I accept the appointment of Agent under this Power of Attorney. This certification and acceptance is made under penalty of perjury.*

Dated this ____ day of _________, 201__.

________________________________ Agent's Signature

________________________________ Print Agent's Name

________________________________ Print Agent's Address

________________________________ Print Agent's Telephone Number

*(NOTE: Perjury is defined in Section 32-2 of the Criminal Code of 1961, and is a Class 3 felony.)