

Missouri
DURABLE POWER OF ATTORNEY FOR HEALTH CARE
AND
HEALTH CARE DIRECTIVE

This form allows you to express your desires concerning your health care.

Part I is your Durable Power of Attorney for Health Care. It allows you to appoint someone to make decisions for you if you are unable to act concerning your health care.

Part II is your Health Care Directive. It allows you to express your intention regarding your future health care.

You may complete the Power of Attorney (Part I) or the Directive (Part II) or both.

Part III provides for notarization. If you intend to use the Durable Power of Attorney For Health Care in Part I, this document must be notarized.

IF THERE IS A STATEMENT WITH WHICH YOU DO NOT AGREE, YOU MAY CHANGE IT AND ADD YOUR INITIALS.

Part I. Durable Power of Attorney for Health Care

- If you do NOT wish to name an agent to make health care decisions for you, write your initials in the box to the right and got to Part II. Initials

_____ Initials

This form has been prepared to comply with the "Durable Power of Attorney for Health Care Act" of Missouri.

1. Selection of Agent. It is suggested that only one Agent be named. However, if more than one Agent is named, any one may act individually unless you specify otherwise.

I appoint: Name: _____

Address: _____

Telephone: _____

as my Agent.

2. Alternate Agents. Only an Agent named by me may act under this Durable Power of Attorney. If my Agent resigns or is not able or available to make health care decisions for me, or if an Agent named by me is divorced from me or is my spouse and legally separated from me, I appoint the person(s) named below (in the order named if more than one):

First Alternate Agent

Name: _____

Address: _____

Telephone: _____

Second Alternate Agent

Name: _____

Address: _____

Telephone: _____



THIS IS A DURABLE POWER OF ATTORNEY, AND THE AUTHORITY OF MY AGENT, WHEN EFFECTIVE, SHALL NOT TERMINATE OR BE VOID OR VOIDABLE IF I AM OR BECOME DISABLED OR INCAPACITATED OR IN THE EVENT OF LATER UNCERTAINTY AS TO WHETHER I AM DEAD OR ALIVE.

3. Effective Date and Durability. Except for such earlier dates as may be set forth in Section 4, below, this Durable Power of Attorney is effective when two physicians decide and certify that I am incapacitated and unable to make and communicate a health care decision.

- **If you want ONE physician, instead of TWO, to decide whether you are incapacitated, write your initials in the box to the right. _____ (Initials)**

4. Agent’s Powers. I grant to my Agent full authority to:

A. Give consent to, prohibit or withdraw any type of health care, medical care, treatment or procedure, even if my death may result.

- **If you wish to AUTHORIZE your Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water), write your initials in the box to the right. _____ (Initials)**
- **If you DO NOT WISH TO AUTHORIZE your Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration, (including tube feeding of food and water), write your initials in the box to the right. _____ (Initials)**

B. Make all necessary arrangements for health care services on my behalf, and to hire and fire medical personnel responsible for my care;

C. Move me into or out of any health care facility (even if against medical advice) to obtain compliance with the decisions of my Agent; and

D. 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 health care provider, and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney.

E. Act, effective immediately, as my “personal representative” as defined in 45 C.F.R. § 164.502(g), the regulations enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and as hereafter amended, for the purpose of authorizing the release of my complete health record as may be necessary in order to obtain for my benefit medical treatment or consultation.

5. Agent’s Financial Liability and Compensation. My Agent acting under this Durable Power of Attorney will incur no personal financial liability. My Agent shall not be entitled to compensation for services performed under this Durable Power of Attorney, but my Agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision hereof.

Part II. Health Care Directive

- If you **DO NOT WISH** to make a health care directive, write your initials in the box to the right, and go to Part III. _____ (Initials)

I make this HEALTH CARE DIRECTIVE (“Directive”) to exercise my right to determine the course of my health care and to provide clear and convincing proof of my wishes and instructions about my treatment.

If I am persistently unconscious or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, I direct that all of the life-prolonging procedures that I have initialled below be withheld or withdrawn.

I want the following life-prolonging procedures to be withheld or withdrawn:

- artificially supplied nutrition and hydration (including tube feeding of food and water) _____ (Initials)
- surgery or other invasive procedures _____ (Initials)
- heart-lung resuscitation (CPR) _____ (Initials)
- antibiotic _____ (Initials)
- dialysis _____ (Initials)
- mechanical ventilator (respirator) _____ (Initials)
- chemotherapy _____ (Initials)
- radiation therapy _____ (Initials)
- all other “life-prolonging” medical or surgical procedures that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury. _____ (Initials)

However, if my physician believes that any life-prolonging procedure may lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time. If it does not improve my condition, I direct the treatment be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

I want to donate my organs or tissues and realize it may be necessary to maintain my body artificially after my death on a breathing machine until my organs can be removed.

Yes No I do not want to address this question now

IF I HAVE NOT DESIGNATED AN AGENT IN THE DURABLE POWER OF ATTORNEY, THIS DOCUMENT IS MEANT TO BE IN FULL FORCE AND EFFECT AS MY HEALTH CARE DIRECTIVE.

Part III. General Provisions Included in the Directive and Durable Power of Attorney

1. Relationship Between Directive and Durable Power of Attorney. If I have executed the Directive and the Durable Power of Attorney, I encourage my Agent to follow my wishes as expressed in the Directive in making decisions regarding life-prolonging procedures. However, I have confidence in my Agent’s ability to make decisions in my best interest, and I authorize my Agent to make decisions that are contrary to my Directive in his or her best judgment. If the Durable Power of Attorney is somehow determined to be ineffective, or if my Agent is not able to serve, the Directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

2. Protection of Third Parties Who Rely on My Agent. No person who relies in good faith upon any representations by my Agent or Alternate Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent’s authority.

3. Revocation of Prior Directive or Durable Power of Attorney. I revoke any prior LIVING WILL, Declaration or Health Care Directive executed by me. If I have appointed an Agent in a prior durable power of attorney, I revoke any health care terms contained in that durable power of attorney.

4. Validity. This document is intended to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be as valid as the original.

YOU MUST SIGN THIS DOCUMENT IN THE PRESENCE OF TWO WITNESSES.

IN WITNESS WHEREOF, I have executed this document this _____ day of _____ (month), _____ (year).

Signature
Print Name _____
Address _____

The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least eighteen years of age.

Signature _____ Signature _____
Print Name _____ Print Name _____
Address _____ Address _____

ONLY REQUIRED FOR PART I — DURABLE POWER OF ATTORNEY

STATE OF MISSOURI)
) SS
COUNTY OF _____)

On this _____ day of _____ (month), _____ (year), before me personally
appeared _____, to me known to be the person described in and
who executed the foregoing instrument and acknowledged that he/she executed the same as his/her
free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the
County of _____, State of Missouri, the day and year first above written.

Notary Public

My Commission Expires: _____