Appointment of Health Care Representative

I, _____, appoint my_____, _____ , as my health care representative who is authorized to act for me in all matters of health care. If my first named health care representative is not reasonably available or declines to act, I appoint my _____ , _____ , as my successor health care representative. If my second named health care representative is not reasonably available or declines to act, I appoint my _____ , _____ , as my successor health care representative. I authorize my health care representative hereby appointed to delegate decision-making power to another by a written delegation.

Health Care Decision-Making Authority:

I authorize my health care representative to make decisions in my best interests. If, based on my previously expressed preferences or my diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may also discuss this decision with my family and others to the extent they are available.

The authority granted to my health care representative under this section of this Appointment becomes effective and remains effective only during such periods of time as I am incapable of consenting to my health care.

HIPAA Release Authority:

My health care representative is my personal representative for purposes of 45 CFR parts 160 through 164. I intend for my health care representative to be treated as I would be treated with respect to my rights regarding the use and disclosure of my medical records and my other individually identifiable health information. This release authority applies to all information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, other covered health care provider, insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose, and release to my health care representative, without restriction, all of my medical records and my other individually identifiable health information regarding any past, present, or future medical or mental health condition including, but not limited to, all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

The authority given to my health care representative under this instrument shall supersede all prior agreements that I may have made with, and all prior instructions that I may have given to, my health care providers to restrict access to or disclosure of my medical records and my other individually identifiable health information. The authority given to my health care representative under this section of this Appointment shall be effective immediately, even though I am capable of consenting to my health care.

Dated this _____ day of _____ , 202__.

Signature: _____ Printed:_____

We declare that we are each adults age eighteen (18) or older and that, at the request of the above-named individual making the appointment, We witness the signing of this document by the declarant on the date noted above.

Witness Signature: _____ Printed:_____

Witness Signature: _____ Printed:_____