GENERAL INFORMATION REGARDING DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. "Health care' means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. Health care decisions also include decisions about life-sustaining procedures, which means any medical procedure, treatment, or intervention which utilizes mechanical or artificial means to sustain, restore, or supplement a spontaneous vital function, and when applied to a person in a terminal condition, would serve only to prolong the dying process. Life sustaining procedure does not include administration of medication or performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

2. The following individuals shall not be designated as the attorney in fact to make health care decisions under a durable power of attorney for health care:

    1. a health care provider attending the principal on the date of execution;
    2. an employee of such a health care provider unless the individual to be designated is related to the principal by blood, marriage, or adoption within the third degree of consanguinity.

3. The power of attorney for health care decisions may be revoked at any time and in any manner by which the principal declarant is able to communicate the intent to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending health care provider upon its communication to the provider by the principal declarant or by another to whom the principal/declarant has communicated the revocation.

4. It is the responsibility of the principal declarant to provide the attending health care provider with a copy of this document.

SUGGESTIONS AFTER FORM IS PROPERLY SIGNED, WITNESSED OR NOTARIZED

1. Provide a copy to the designated attorney-in-fact (agent) and to alternate designated attorney-in-fact (if any).
2. Place original in a safe place known and accessible to family members or close friends.
3. Provide a copy to your doctor.
4. Provide a copy(s) to family member(s).

NOTE: For additional copies of this form, go to the Iowa Legal Aid Website (iowalegalaid.org). You may go directly to a pdf file of this document by putting www.iowalegalaid.org/link.cfm?900 in your browser.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS
(Medical Power of Attorney)

I, _____, hereby designate _____, of

_____,
(address, city, state and telephone number)
as my attorney-in-fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health care decisions. The attorney-in-fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of the State of Iowa, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document. My agent has the right to examine my medical records and to consent to disclosure of such records. I also appoint my agent as my Personal Representative (as that term is used in the Health Insurance Portability and Accountability Act of 1996, as amended, and its promulgating regulations) and to have access to my personally identifiable health care and related information of all kinds in any form, and to execute any other document that may be required or requested in order to do so.

Additional provisions:

If the person designated as agent above is unable or unwilling to serve, I designate the following person to serve as my agent with the power to make health care decisions for me:

_____
_____(name, address and telephone number).

Signed this ____ day of_____, _____.

_____
(Signature of Declarant/Principal)
Address: _____
_____
SSN:#_____

IMPORTANT NOTE: THIS DOCUMENT MUST BE SIGNED BEFORE A NOTARY PUBLIC OR TWO WITNESSES. IF YOU HAVE QUESTIONS REGARDING THIS FORM OR NEED ASSISTANCE TO COMPLETE IT, YOU SHOULD CONSULT AN ATTORNEY.

(OVER)

NOTARY PUBLIC FORM

STATE OF IOWA, COUNTY OF _____, SS:

On this_____ day of _____, _____, before me, the undersigned, a Notary Public in and for said state, personally appeared _____, to me known to be the person named in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her voluntary act and deed.

_____
Notary Public in and for the State of Iowa

WITNESS FORM

We, the undersigned, hereby state that:

- we signed this document in the presence of each other and the Declarant;
- we witnessed the signing of the document by the Declarant or by another person acting on behalf of the Declarant at the direction of the Declarant;
- neither of us are health care providers who are presently treating the Declarant, or employees of such a health care provider;
- we are both at least 18 years of age; and
- at least one of us is not related to the Declarant by blood, marriage or adoption.

_____	_____
Signature of 1st Witness	Signature of 2nd Witness
_____	_____
(Type or Print Name of Witness)	(Type or Print Name of Witness)
_____	_____
Street Address	Street Address
_____	_____
City State Zip Code	City State Zip Code