NORTON COUNTY HOSPITAL

Durable Power of Attorney for Health Care Decisions

I, ______________________________, ________________ appoint the person named below
(print name) *(date of birth)*

to be my agent to make health care decisions for me as authorized in this document:

Name of Agent: ____________________________________
Address: ____________________________________
Phone: ____________________________________
(day) *(evening)*

In the event the above-named agent is unwilling or unable to act as my agent, I hereby appoint the following persons to so serve, in the order listed below. *If you DO NOT want to name an alternate agent, write "none" on the name lines below.*

First Alternate Agent:
Name: ____________________________

Address: ____________________________

Phone: ____________________________

Second Alternate Agent:
Name: ____________________________

Address: ____________________________

Phone: ____________________________

This power of attorney for health care decisions shall be effective immediately, and shall not be affected by my subsequent disability or incapacity. I grant my agent full power to make all decisions for me about my health care consistent with my expressed desires, except that such authority shall ***not*** include the ability to revoke or invalidate any declaration made by me in accordance with the Kansas Natural Death Act or other living will declaration ("Living Will"). My agent is also authorized to:

- Consent, refuse or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition (including the refusal or withdrawal of consent for the use of life-sustaining treatments and procedures), and make decisions about organ donation, autopsy and disposition of my body.
- Make all necessary arrangements at any hospital, psychiatric treatment facility, hospice, nursing home or other health care organization, employ or discharge health care personnel (any person authorized or permitted by the law to provide health care services) as my agent shall deem necessary for my physical, mental or emotional well-being;
- Request, receive and review any information, verbal or written, regarding my physical or mental health or my personal affairs, including medical and hospital records, and execute any releases or other documents to obtain such information;
- Move me into or out of any State or institution for the purpose of complying with my Health Care Declaration or the decisions of my agent;
- Take legal action, if needed, to do what I have directed; and
- Become my guardian, if one is needed.

(If you DO NOT want your agent to be able to do one or more of the above actions, draw a line through it and write your initials at the end of line.)

This revokes any prior Durable Power of Attorney for Health Care Decisions which I have previously made. My agent may not appoint anyone else to make decisions for me. I and my estate hold my agent and my caregivers harmless against any claim based upon any decision made or action taken based upon the authority of this Durable Power of Attorney for Health Care Decisions.

Signature: _______________________________ Date: __________________________

This document must be dated and signed in the presence of two witnesses ***OR*** *acknowledged before a notary public.*

Witnesses- two persons of lawful age, who are not your agent, not related to you, not entitled to any portion of your estate, and not financially responsible for your health care:

Witness: _________________________ Witness: __________________________

Address: _________________________ Address: __________________________

Notary- On this the _____ day of ______________________, 20____, this instrument was acknowledged before me in the County of _________________, State of Kansas, on the day written above.

Signature of Notary Public: _________________________

My appointment expires: _________________________