1. Power of Attorney for Health Care   
   of   
   {{ spouse.name }}

I, {{ spouse.name }}, the principal, an adult of sound mind, execute this Power of Attorney for Health Care freely and voluntarily, with an understanding of its purposes and consequences. I intend to create a medical durable power of attorney under the laws of the State of Illinois. I further intend to demonstrate my wishes concerning medical treatment with clear and convincing evidence. I hereby revoke any Power of Attorney for Health Care previously granted by me as principal including powers granted by me under any state statutory Power of Attorney for Health Care. This Power of Attorney for Health Care shall become effective immediately upon its execution.

# Recitals

## Designation of Agent

{%p if hc\_number\_s == 1 %}

I designate the individual named below to serve as my Agent. I give my Agent the power to make decisions with regard to my health care if I am unable to make my own health care decisions.

Name: {{ hcpoagentsspouse[0].name }}

Address:

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

{%p elif hc\_number\_s == 2 %}

I designate the individual named below to serve as my Agent. I give my Agent the power to make decisions with regard to my health care if I am unable to make my own health care decisions.

Name: {{ hcpoagentsspouse[0].name }}

Address:

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If {{ hcpoagentsspouse[0].name }} is unwilling or unable to serve, I designate the individual listed below as alternate Agent to exercise the powers and discretions set forth in this instrument.

Name: {{ hcpoagentsspouse[1].name }}

Address:

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

{%p else %}

I designate the individual named below to serve as my Agent. I give my Agent the power to make decisions with regard to my health care if I am unable to make my own health care decisions.

Name: {{ hcpoagentsspouse[0].name }}

Address:

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If {{ hcpoagentsspouse[0].name }} is unwilling or unable to serve, I designate the individuals listed below, in the order listed, as alternate Agents to exercise the powers and discretions set forth in this instrument.

{%p macro information(agent) %}

Name: {{ agent }}

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

{%p endmacro %}

{%p for agent in hcpoagentsspouse[1:] %}

{{p information(agent) }}

{%p endfor %}

{%p endif %}

## Duration

This Power of Attorney for Health Care is not limited to a term of years; it will terminate upon its revocation as provided in this instrument or upon my death, whichever event occurs first. My Agent’s authority does not terminate if I become disabled or incapacitated.

The powers granted to my agent related to anatomical gifts, autopsy and disposition of my remains shall survive my death, and shall remain in effect for a period of time sufficient to allow my agent to carry out his or her authority with regard to such provisions.

## General Grant

My Agent may determine and implement all actions necessary for my personal care, residential placement, and medical treatment, including the items specifically mentioned in this instrument. If my Agent is not available, I intend to guide decisions about my care and treatment as set forth in this document.

## Effect on Legal Capacity

A formal adjudication of my incapacity is not required for my Agent to exercise the authority granted by me under this instrument.

## Limitations Applicable to My Spouse

Whenever my spouse is serving as my agent, if my spouse or I file a petition for legal separation, annulment, declaration of invalidity of marriage, or dissolution of marriage and unless and until the petition is dismissed, my spouse, my spouse’s parents, all of my spouse’s descendants who are not my descendants and all spouses of such persons who are not descendants of my parents will be deemed to have died intestate on the date of the filing for all purposes of this instrument. If, however, a court issues any order dismissing a petition described above, and I accept the dismissal of the petition by a written acknowledgement, then the persons identified in this paragraph will no longer be deemed to have died intestate for purposes of this instrument.

# Health and Personal Powers

## Instructions Concerning Medical Evaluations and Treatment

In exercising the authority granted to my Agent, I instruct my Agent to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner however rudimentary, even by blinking my eyes. I further instruct my Agent that if I am unable to give an informed consent to medical treatment, my Agent shall give or withhold consent based upon any treatment choices I have expressed to my agent while competent, whether under this instrument or otherwise. If my Agent cannot determine the treatment choice I would want made under the circumstances, then I request that my Agent make the choice for me based upon what my Agent believes to be in my best interests. I request that my Agent’s decision be guided by taking into account:

the provisions of this instrument;

any preferences that I may have expressed to my agent on the subject;

what my Agent believes I would want done in the circumstances if I were able to express myself; and

any information given to my Agent by the physicians treating me as to my medical diagnosis and prognosis and the intrusiveness, pain, risks, and side effects of the treatment.

I want to leave my family, friends, and persons who care about me with assurances of my love, and without the burdens of guilt or conflict. My purposes in leaving these instructions are to alleviate uncertainty that otherwise may arise in connection with decisions about my medical care, to promote family harmony, and to clarify instructions to my health care providers.

If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death delaying procedures, I direct that my agent withhold or withdraw such procedures which would only prolong the dying process, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

I affirm my belief in the importance and value of my personal dignity, both in living and in dying.

## Supervision of my Care

My Agent is authorized to:

**Care Manager** - employ a care manager to supervise and monitor my care upon such terms and conditions as my agent deems appropriate.

**Companion** - provide for a companion for me upon such terms and conditions as my agent deems appropriate.

## Authority to discharge medical providers

My agent is authorized to employ or discharge medical personnel, including physicians, psychiatrists, dentists, nurses and therapists, as my agent shall deem necessary for my physical, mental and emotional well-being and to pay them reasonable compensation.

## Patient Advocate

My agent is authorized to appoint a patient advocate for me, who may be any person so designated by my agent. My patient advocate shall have the same right to ask questions and receive information regarding my medical condition(s), treatment, and any proposed treatment as I and my agent would have, and the right to be in attendance to me at all times.

## Access to Family

I direct my agent to grant me full access to the members of my immediate family, and to grant my immediate family full access to me, and not to prevent me from seeing or communicating with the members of my immediate family under any circumstances.

## Indemnification

I release and discharge my agent from liability for negligent action.

## Long-Term or Hospice Care

My Agent may select a facility for my nursing, convalescent, or hospice care and establish my residence and placement in a secure unit therein if the facility provides the quality of care appropriate for my medical needs and mental condition. For the purposes of arranging or providing long-term care, my Agent has authority to facilitate my transportation and establish my legal residence within or beyond the state of Illinois.

## Maintain Me in My Residence

I authorize my Agent to take whatever steps are necessary or advisable to enable me to remain in my personal residence as long as it is reasonable in the opinion of my agent. I realize that my health may deteriorate so that it becomes necessary to have round-the-clock nursing care if I am to remain in my personal residence, and I direct my Agent to obtain that care, including any equipment that might assist in my care, as is reasonable under the circumstances. Specifically, I do not want to be hospitalized or put in a convalescent or similar home as long as it is reasonable to maintain me in my personal residence.

## Employ and Discharge Health Care Personnel

My Agent may employ and discharge medical personnel including physicians, psychiatrists, dentists, nurses, and therapists as my Agent determines necessary for my physical, mental, and emotional well-being, and seek payment of reasonable compensation for their services.

## Pain Relief

I want to ensure that my Agent and physician protect my comfort and freedom from pain insofar as possible. I authorize my Agent to consent on my behalf to the administration of whatever pain-relieving drugs and pain-relieving surgical procedures my Agent, upon medical advice, believes may provide comfort to me, even though such drugs or procedures may lead to pharmaceutical addictions, lower blood pressure, lower levels of breathing, or hasten my death. Even if artificial life support or aggressive medical treatment has been withdrawn or refused, I want to be kept as comfortable as possible, and I do not want to be neglected by medical or nursing staff.

## Consent to Psychiatric Treatment

Upon the execution of a certificate by two independent psychiatrists who have examined me and in whose opinions I am in immediate need of hospitalization because of mental disorders, alcoholism, or drug abuse, my Agent may arrange for my voluntary admission to an appropriate hospital or institution for treatment of the diagnosed problem or disorder; to arrange for private psychiatric and psychological treatment for me; and to revoke, modify, withdraw, or change consent to the hospitalization, institutionalization, or private treatment that I or my Agent may have previously given. The consent of my Agent to my hospitalization for psychiatric help, alcoholism, or drug abuse has the same legal effect, subject to applicable local law, as a voluntary admission made by me.

## Grant Releases

My Agent may grant, in conjunction with any instructions given under this instrument, releases from all liability for damages suffered or to be suffered by me to hospital staff, physicians, nurses, and other medical and hospital administrative personnel who act in reliance on instructions given by my Agent or who render written opinions to my Agent in connection with any matter described in this instrument. My Agent may sign documents titled or purporting to be a Refusal to Permit Treatment and Leaving Hospital Against Medical Advice as well as any necessary waivers of or releases from liability required by any hospital or physician to implement my wishes regarding medical treatment or non-treatment.

## Living Will

I have executed a Living Will under the laws of the state of Illinois. To the extent that any provisions of this Power of Attorney for Health Care conflict with my Living Will, the provisions of my Power of Attorney for Health Care will prevail, and the decisions of my Health Care Agent will be honored.

If I become unconscious or incompetent in a state where my Living Will or this Power of Attorney for Health Care is not enforceable, I authorize my Agent to transport me or arrange for my transportation to a jurisdiction where my medical directives will be enforceable.

## Anatomical Gifts for Any Purposes

I authorize my Agent to make anatomical gifts on my behalf to the persons and organizations my Agent chooses for any purpose, including transplantation and medical research. My Agent may execute the papers and act as necessary, appropriate, incidental, or convenient in connection with these gifts.

## Autopsy and Disposition of Remains

My agent shall also have 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. 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 or both, funeral director or embalmer, or funeral establishment who receives a copy of this document to act under it.

# Legal and Administrative Powers and Provisions

## Health Insurance Portability and Accountability Act

I grant my Agent the power and authority to serve as my authorized recipient for all purposes of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its regulations immediately upon my signing this document.

Pursuant to HIPAA, I specifically authorize my Agent as my HIPAA-authorized recipient to request, receive, and review any information regarding my physical health, including all HIPAA-protected health information, medical, and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required to obtain this information; and to consent to the disclosure of this information. I further authorize my Agent to execute on my behalf valid authorizations for the release of HIPAA-protected health information.

By signing this Health Care Power of Attorney, I specifically authorize my physician, hospital, or health care provider to release any medical records to my Agent or any person designated in a valid authorization for the release of HIPAA-protected health information executed by my Agent. Further, I waive any liability to any physician, hospital, or health care provider that releases any of my medical records to my Agent and acknowledge that the health information that would otherwise be protected under HIPAA will no longer be protected.

## Guardian

I intend hereby to render unnecessary any future proceeding for a court-appointed guardian of the person for me in the event I become temporarily or permanently incapacitated or incompetent. Accordingly, I request in the strongest possible terms that any court which may receive or act upon a petition for the appointment of a guardian of my person should deny such petition so long as my agent is acting under this Power of Attorney. I direct that if a guardian of my person is ever appointed for me in spite of this request that my agent be named as my guardian. If my agent is unable or unwilling to serve as my guardian, I nominate the successor agent named in this instrument as the guardian of my person.

## Third-Party Reliance

My Agent’s instructions and decisions regarding my medical treatment are binding on third parties. No person, medical facility, or institution will incur any liability to me or to my estate by complying with my Agent’s instructions. My Agent is authorized to execute consents, waivers, and releases of liability on my behalf and on behalf of my estate to all medical personnel who comply with my Agent’s instructions. Furthermore, I authorize my Agent to indemnify and hold harmless, at my expense, any third party who accepts and acts under this Power of Attorney for Health Care, and I agree to be bound by any indemnity entered into by my Agent.

## Enforcement by Agent

I authorize my Agent to seek on my behalf and at my expense:

a declaratory judgment from any court of competent jurisdiction interpreting the validity of this instrument or any of the acts authorized by this instrument, but a declaratory judgment is not required for my Agent to perform any act authorized by this instrument;

an injunction requiring compliance with my Agent’s instructions by any person providing medical or personal care to me; or

actual and punitive damages against any person responsible for providing medical or personal care to me who willfully fails or refuses to follow my Agent’s instructions.

## Release of Agent’s Personal Liability

My Agent will not incur any personal liability to me or my estate arising from the good faith exercise of discretion or performance of acts and duties relating to my medical treatment and personal care.

## Reimbursement of Agent

My Agent is entitled to reimbursement for all reasonable expenses arising from the performance of acts and duties relating to my medical treatment and personal care under this instrument.

## Copies Effective as Originals

Photocopies of this instrument are effective and enforceable as originals, and third parties are entitled to rely on photocopies of this instrument for the full force and effect of all stated terms. The word *photocopies* includes facsimiles, digital, or other reproductions.

## Interstate Enforceability

My intention is that the terms of this instrument be honored in any jurisdiction, regardless of its conformity to that jurisdiction’s technical requirements and legal formalities.

## Amendment and Revocation

I reserve the right to revoke my Agent’s authority as long as I have capacity to do so. If I am deemed to lack, or if I am deemed to have lacked, capacity at the time of revocation, as determined by a qualified medical professional, such revocation shall be ineffective and of no force and effect. I can revoke or amend this power only by a clear and unequivocal written expression of my intent to do so.

## Revocation of Prior Powers

Unless specifically excepted in this instrument, this Power of Attorney for Health Care supersedes any prior medical durable power of attorney that I have executed including powers granted by me under any state statutory Power of Attorney for Health Care. But this instrument does not affect any other unrelated powers previously conveyed by me through general or limited powers of attorney, including Powers of Attorney for Property, or my Living Will; these powers and Living Will are to continue in full force until revoked by me or otherwise terminated.

Dated: \_\_\_\_\_\_\_\_\_\_ \_\_\_, 20\_\_\_

{{ spouse.name }}, Principal

**Delayed Revocation**

I elect to delay revocation of this power of attorney for 30 days after I communicate my intent to revoke it.

I elect for the revocation of this power of attorney to take effect immediately if I communicate my intent to revoke it.

**Witness Attestation**

The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence. I certify that I am at least 18 years old and that I am not: (a) an agent or successor agent named in this document; (b) a parent, sibling, or descendant, or the spouse of a parent, sibling, or descendant, of either the principal or any agent or successor agent, regardless of whether the relationship is by blood, marriage, or adoption; (c) the physician, advanced practice nurse, physician assistant, dentist, podiatric physician, optometrist, or mental health service provider of the principal, or a relative of the physician, advanced practice nurse, physician assistant, dentist, podiatric physician, optometrist, or mental health service provider of the principal; (d) an owner, operator, or the relative of an owner or operator, of the health care facility in which the principal is a patient or resident.

Witness printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s date: \_\_\_\_\_\_\_\_\_\_ \_\_\_, 20\_\_\_

STATE OF ILLINOIS )

) ss

COUNTY OF {{ county }} )

The undersigned, a notary public in and for the above county and state, certifies that {{ spouse.name }} and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, known to me to be the same person whose name is subscribed to the foregoing document, appeared before me in person and acknowledged signing and delivering the instrument as his or her free and voluntary act, for the uses and purposes therein set forth.

Dated: \_\_\_\_\_\_\_\_\_\_ \_\_\_, 20\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Notary Public

My commission expires: \_\_\_/\_\_\_/ 20\_\_\_

This document was prepared by: Estate lawyers, PLLC

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