1. Health Care Advance Directive   
   of   
   {{ client.name }}

I, {{ client.name }}, the principal, an adult more than 18 years of age and of sound mind, execute this Health Care Advance Directive pursuant to Indiana Code §16-36-7-1 et seq, freely and voluntarily, with an understanding of its purposes and consequences. I intend my statements in this document to constitute clear and convincing evidence of my wishes concerning health care, including the designation of a Healthcare Agent, a Living Will declaration made under Indiana Code §16-36-4-10, and an anatomical gift made under Indiana Code §29-2-16.1.

# Recitals

## Designation of Healthcare Agent

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

I designate {{ hcpoagentsclient[0].name }} to serve as my Healthcare Agent. I give my Healthcare Agent the power to make decisions with regard to my health care if I am unable to make my own health care decisions.

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

I designate {{ hcpoagentsclient[0].name }} to serve as my Healthcare Agent. I give my Healthcare Agent the power to make decisions with regard to my health care if I am unable to make my own health care decisions.

If {{ hcpoagentsclient[0].name }} is unwilling or unable to serve, I designate {{ hcpoagentsclient[1].name }} as alternate Healthcare Agents to exercise the powers and discretions set forth in this instrument.

{%p else %}

I designate {{ hcpoagentsclient[0].name }} to serve as my Healthcare Agent. I give my Healthcare Agent the power to make decisions with regard to my health care if I am unable to make my own health care decisions.

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

{%p for agent in add\_separators(hcpoagentsclient[1:], separator=‘, Alternate’, last\_separator=‘, Alternate’, end\_mark=‘, Alternate’) %}

{{ agent }}

{%p endfor %}

{%p endif %}

## Effectiveness and Duration

Except as otherwise specifically provided for, the appointment of my Healthcare Agent shall not become effective until such time as I become incapable of consenting to, or withholding consent for medical treatment as determined by my regular physician, and shall last only so long as the incapacity continues.  In the event that my physician is unavailable or if consultation would be unadvisable due to the existence of some emergency, then my attending physician shall determine the extent to which I am capable of making decisions with regard to my medical treatment and health care decisions.  This instrument is not limited to a term of years; it shall terminate only upon its revocation pursuant to the provisions of this power, or upon my death, whichever event first occurs.

## General Grant

My Healthcare Agent has authority to do all acts related to my personal care, residential placement, and medical treatment which my Healthcare Agent may deem appropriate, including but not limited to authority with respect to health care pursuant to Indiana Code §16-36-7-36, as it exists now and as it may be amended in the future, and the items specifically mentioned hereafter. My Healthcare Agent shall be considered my Health Care Representative, to act on my behalf pursuant to Indiana Code §16-36-7-1 et seq. with regard to questions of medical services, and to consent to, or withhold consent for, medical treatment, emergency or otherwise, if at any time I should be incapable of giving, or withholding, said consent on my own behalf. Even if my Healthcare Agent is not available, I intend the following statements to guide decisions about my care and treatment.

## Effect on Legal Capacity

My Healthcare Agent’s exercise of authority shall not require or imply a formal adjudication of my incapacity.

# Health and Personal Powers

## Instructions Concerning Medical Evaluations and Treatment as Well as Withholding or Withdrawal of Health Care

I authorize my Healthcare Agent to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time, based upon my previously expressed preferences and the diagnosis and prognosis, my Healthcare Agent 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 Healthcare Agent 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 Healthcare Agent must try to discuss this decision with me. However, if I am unable to communicate, my Healthcare Agent may make such decisions for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my Healthcare Agent may also discuss this decision with my family and others, to the extent they are available. In making this decision, I request my Healthcare Agent and family consider the following:

My diagnosis and prognosis;

The risks, benefits, and burdens to me of treatment;

The emotional burdens on my family;

The financial burdens on my family;

My statements of preference regarding health care as expressed in this document;

Other statements regarding health care I have made, giving most weight to my most recent statements;

My ethical and religious principles.

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. My Healthcare Agent’s authority to act on my behalf concerning my medical care includes, but is not limited to, decisions concerning artificial life support, medical treatment, surgery and other medical procedures; artificial nourishment and hydration; resuscitation decisions (including Do Not Resuscitate [DNR] orders, CPR directives, and POST forms); amputation of my limbs; blood transfusions; experimental drugs and medical procedures; the administration of pharmaceutical agents; and arrangements for my long-term care.

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

## Long-Term or Hospice Care

My Healthcare Agent is authorized to select a facility for my nursing, convalescent or hospice care and to establish my residence and placement in a secure unit therein if, in my Healthcare Agent’s sole and exclusive discretion, such 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 Healthcare Agent has authority to facilitate my transportation and establish my legal residence within or beyond the state of Indiana.

## Maintain Me in my Residence

My Healthcare Agent is authorized to take whatever steps are necessary or advisable to enable me to remain in my personal residence as long as it is reasonable under the circumstances. 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 Healthcare Agent to obtain such care, including any equipment that might assist in such 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.

## Medical Records and Admissions to Health Care Facilities

Acting on my behalf my Healthcare Agent may have access to all of my medical information and records; may disclose medical and related information concerning my treatment to appropriate persons or entities; may admit or transfer me to such hospitals, hospices, or treatment facilities as my Healthcare Agent deems to be in my best interests.

## Access to Confidential Health Care Information and HIPAA Release Authority

I intend for my Healthcare Agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively “HIPAA”), 42 USC 1320d and 45 CFR 160-164, as may be amended. I intend that my Healthcare Agent be treated as a “Personal Representative” as that term is used in HIPAA. I authorize:

Any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health-care provider, any 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 Healthcare Agent, without restriction

All of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illnesses, and drug or alcohol abuse.

The authority given my Healthcare Agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. Notwithstanding anything else in this agreement to the contrary, the authority given my Healthcare Agent in this Section is effective immediately, has no expiration date, and shall expire only in the event that I revoke the authority in writing and deliver it to my health-care provider.

## Employ and Discharge Health Care Personnel

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

## Pain Relief

My comfort and freedom from pain are important for my Healthcare Agent and physician to protect, insofar as possible. I authorize my Healthcare Agent to consent on my behalf to the administration of whatever pain-relieving drugs and surgical pain relieving procedures my Healthcare 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 may 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

My Healthcare Agent is authorized to arrange (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) 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 such hospitalization, institutionalization or private treatment which I or my Healthcare Agent may have previously given. The consent of my Healthcare Agent to my hospitalization for psychiatric help, alcoholism or drug abuse shall have the same legal effect, subject to applicable local law, as a voluntary admission made by me.

## Grant Releases

My Healthcare Agent is authorized to grant, in conjunction with any instructions given under this document, releases to hospital staff, physicians, nurses and other medical and hospital administrative personnel who act in reliance on instructions given by my Healthcare Agent or who render written opinions to my Healthcare Agent in connection with any matter described in this document from all liability for damages suffered or to be suffered by me; and to 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 separate Living Will declaration under the laws of the state of Indiana. To the extent that any provisions of this Health Care Power of Attorney or decisions of my Healthcare Agent are deemed to conflict with my separate Living Will, the provisions of my Health Care Power of Attorney shall prevail, and the decisions of my Healthcare Agent shall be honored.

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

# Legal and Administrative Powers and Provisions

## Guardian

The authority conferred upon my Healthcare Agent shall obviate the need for appointment of a guardian of my person. However, should any proceeding commence for appointment of a guardian of my person, I nominate my Healthcare Agent to serve as guardian, without bond.

## Third-Party Reliance

Third parties shall accept as binding the instructions and decisions of my Healthcare Agent regarding my medical treatment. No person or medical facility or institution shall incur any liability to me or to my estate by complying with my Healthcare Agent’s instructions. My Healthcare 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 Healthcare Agent’s instructions. Furthermore, I authorize my Healthcare Agent to indemnify and hold harmless, at my expense, any third party who accepts and acts under this document, and I agree to be bound by any such indemnity entered into by my Healthcare Agent.

## Enforcement by Healthcare Agent

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

A declaratory judgment from any court of competent jurisdiction interpreting the validity of this document or any of the acts authorized by this document, but such declaratory judgment shall not be necessary in order for my Healthcare Agent to perform any act authorized by this document; and/or

An injunction requiring compliance with my Healthcare Agent’s instructions by any person providing medical or personal care to me; and/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 Healthcare Agent’s instructions.

## Release of Healthcare Agent’s Personal Liability

My Healthcare Agent shall 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 Healthcare Agent

My Healthcare Agent shall be entitled to reimbursement for all reasonable expenses arising from the performance of acts and duties relating to my medical treatment and personal care pursuant to this document.

## Copies Effective as Originals

Photocopies of this document shall be effective and enforceable as originals, and third parties shall be entitled to rely on photocopies of this document for the full force and effect of all stated terms.

## Interstate Enforceability

It is my intention that the terms of this document 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 Healthcare Agent’s authority orally or in writing.

## Revocation of Prior Powers

Unless otherwise expressly provided herein, this Health Care Advance Directive expressly supersedes all prior medical durable powers of attorney or directives which I previously may have executed. Execution of this document does not, however, affect any other unrelated powers previously conveyed by me through general or limited powers of attorney, or my Living Will which powers and Living Will are to continue in full force and effect until revoked by me or otherwise terminated.

[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK]

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

{{ client.name }}, Principal

{{ address.address }},

{{ address.city }}, {{ address.state }} {{ address.zip }}

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: {{ client.birthdate }}

On \_\_\_\_\_\_\_\_\_\_ \_\_\_, 20\_\_\_, {{ client.name }} (the “Declarant”) signified to me that this Health Care Advance Directivewas being made by the Declarant freely and voluntarily and, in my presence, the Declarant signed this Health Care Advance Directive; and I, at the Declarant’s request, and in the Declarant’s presence and in the presence of the other witness, signed my name as witness. I further state that the Declarant has been personally known to me, and is believed by me to be of sound mind. I did not sign the Declarant’s signature above for or at the direction of the Declarant. I am not a parent, spouse, or child of the Declarant, and am not, to the best of my knowledge, entitled to any part of the Declarant’s estate and am not financially responsible for the Declarant’s medical care. I am competent and over eighteen (18) years old.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE OF INDIANA )

) ss.

COUNTY OF {{ county }} )

This instrument was acknowledged before me on \_\_\_\_\_\_\_\_\_\_ \_\_\_, 20\_\_\_, by {{ client.name }}.

Notary Public

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