

STATE OF ILLINOIS
NOTICE TO THE INDIVIDUAL SIGNING THE
**ILLINOIS STATUTORY SHORT FORM
POWER OF ATTORNEY FOR HEALTH CARE**

755 ILCS 45/4-10

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your "health care agent." Your agent is the person you trust to make health care decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an "advance directive." You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and online resources to guide you and your loved ones in having a conversation about these issues.

The form that you will be signing is a legal document. It is governed by the Illinois Power of Attorney Act (755 ILCS 45/4-1 et seq.). If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

Please place your initials on the following line indicating that you have read this Notice: **T.R.C.**
Principal's initials

ILLINOIS STATUTORY SHORT FORM

POWER OF ATTORNEY FOR HEALTH CARE

1. I, **Thomas R. Castellano**, residing at 2847 North Lakewood Avenue, Chicago, Illinois 60614, hereby revoke all prior powers of attorney for health care executed by me and appoint:

Health Care Agent: Maria E. Castellano (Spouse)

Address: 2847 North Lakewood Avenue, Chicago, Illinois 60614

Telephone: (312) 555-0726

Email: mecastellano@email.example.com

as my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care, and to require, withhold, or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others as my agent sees fit. This authorization applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2. **SUCCESSOR AGENT.** If the agent named above is unable or unwilling to serve, I appoint:

Successor Health Care Agent: Lisa K. Ferraro (Sister)

Address: 1205 South Ridgeland Avenue, Oak Park, Illinois 60302

Telephone: (708) 555-0215

3. **SPECIFIC INSTRUCTIONS AND LIMITATIONS** (pursuant to Section 4-10 of the Illinois Power of Attorney Act):

End-of-Life Decisions:

(a) If I am suffering from a terminal condition with no reasonable chance of recovery and am unable to communicate my wishes, I direct my agent to refuse or withdraw all life-sustaining treatment, including artificial nutrition and hydration, mechanical ventilation, and dialysis. I request that comfort care and pain management be provided.

(b) If I am in a persistent vegetative state or irreversible coma, I direct my agent to refuse or withdraw all life-sustaining treatment. I understand that this may result in my death.

Organ and Tissue Donation:

(c) Upon my death, I hereby authorize the donation of my organs and tissues for transplantation, therapy, or medical research, in accordance with the Illinois Revised Uniform Anatomical Gift Act (755 ILCS 50/).

Disposition of Remains:

(d) I direct that my remains be cremated. My ashes shall be interred at Holy Sepulchre Cemetery in Alsip, Illinois, in the Castellano family plot. All decisions made by my agent with respect to the disposition of my remains, including cremation, shall be binding pursuant to the Disposition of Remains Act, 755 ILCS 65/1 et seq.

Mental Health Treatment:

(e) I authorize my agent to consent to mental health treatment and to have access to my mental health records. However, my agent may NOT consent to my admission to a mental health facility for more than 17 days, nor consent to electroconvulsive therapy, psychosurgery, or other experimental procedures without a court order.

Additional Wishes:

(f) I wish to be treated at Northwestern Memorial Hospital in Chicago, Illinois whenever reasonably feasible. My primary care physician is Dr. Sarah M. Peterson, whose office is located at 680 North Lake Shore Drive, Suite 1240, Chicago, IL 60611, phone (312) 555-8190.

(g) I am of Italian heritage and Catholic faith. I request that if I am near death, a Catholic priest be contacted to administer the Sacrament of the Anointing of the Sick. My parish is St. Alphonsus, located at 1429 West Wellington Avenue, Chicago, IL 60657, phone (312) 555-6744.

4. EFFECTIVE DATE AND DURABILITY. This Power of Attorney for Health Care shall be effective upon my inability to make or communicate health care decisions, as determined by my attending physician. It is durable and shall not be affected by my disability or incapacity.

5. REVOCATION. I understand that I have the right to revoke this Power of Attorney at any time by communicating my intent to revoke to my agent and/or my attending physician, either in writing or by any other means.

I, Thomas R. Castellano, the Principal, sign my name to this Statutory Short Form Power of Attorney for Health Care on January 22, 2025.

Thomas R. Castellano

Principal

Date: January 22, 2025

WITNESS

I declare under penalty of perjury under the laws of the State of Illinois that the person who signed this document, or asked another to sign for him, did so in my presence, and that to the best of my knowledge, the Principal is of sound mind and is not acting under duress, fraud, or undue influence. I am at least 18 years of age, and I am not the agent designated in this Power of Attorney.

Sandra J. Okonkwo

Witness - 1120 West Diversey Parkway, Chicago, IL 60614

Date: January 22, 2025

NOTARY ACKNOWLEDGMENT

STATE OF ILLINOIS
COUNTY OF COOK

On this 22nd day of January, 2025, before me, a Notary Public in and for said County and State, personally appeared Thomas R. Castellano, known to me to be the person whose name is subscribed to the within instrument, and acknowledged that he executed the same of his own free will, for the purposes therein stated.

Michael P. Harrington

Notary Public, State of Illinois My Commission Expires: August 14, 2027

Date: January 22, 2025

AGENT'S ACCEPTANCE

I, Maria E. Castellano, accept my appointment as Health Care Agent under this Statutory Short Form Power of Attorney for Health Care. I understand my responsibilities and agree to act in the best interest of the Principal, following the instructions and wishes set forth in this document.

Maria E. Castellano

Health Care Agent

Date: January 22, 2025

DISCLAIMER: This document is a sample generated for demonstration and testing purposes only. It is NOT a valid legal document and should NOT be used for any legal purpose. All names, addresses, and identifying information are fictional.