MEDICAL POWER OF ATTORNEY & HEALTHCARE DIRECTIVE

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INSTRUCTIONS FOR USE
This combines a Healthcare Power of Attorney (appointing a healthcare agent) with an Advance Directive (Living Will). Many states have specific statutory forms — check your state's requirements. Most states require notarization and/or witnesses. This does not constitute legal advice.

ADVANCE HEALTHCARE DIRECTIVE

Date: [DATE]

PART 1: HEALTHCARE POWER OF ATTORNEY

I, [FULL LEGAL NAME] ("Principal"), of [CITY], [STATE], currently residing at [FULL ADDRESS], being of sound mind, hereby designate the following person as my Healthcare Agent to make medical decisions on my behalf if I become unable to make or communicate my own healthcare decisions:

Primary Healthcare Agent:

- Name: [FULL LEGAL NAME]
- Address: [ADDRESS, CITY, STATE, ZIP]
- Phone (Home): [PHONE]
- Phone (Cell): [PHONE]
- Email: [EMAIL]
- Relationship: [RELATIONSHIP]

Alternate Healthcare Agent (if Primary is unavailable):

- Name: [FULL LEGAL NAME]
- Address: [ADDRESS, CITY, STATE, ZIP]
- Phone: [PHONE]
- Relationship: [RELATIONSHIP]

Second Alternate (if both above are unavailable):

- Name: [FULL LEGAL NAME]
- Phone: [PHONE]
- Relationship: [RELATIONSHIP]

AGENT'S AUTHORITY

My Healthcare Agent shall have the authority to:

(a) Consent to, refuse, or withdraw consent for any medical treatment, procedure, or service, including life-sustaining treatment;

(b) Access my medical records and health information (HIPAA authorization);

(c) Choose or discharge healthcare providers and facilities;

(d) Consent to admission to or discharge from any hospital, nursing home, assisted living, or hospice facility;

(e) Make decisions about pain management, palliative care, and comfort measures;

(f) Consent to or refuse diagnostic tests, medications, and surgical procedures;

(g) Authorize organ and tissue donation (unless I specify otherwise below);

(h) Authorize autopsy (unless I specify otherwise below);

(i) Direct the disposition of my remains after death.

LIMITATIONS ON AGENT (if any):

[ ] My Agent may NOT authorize: [SPECIFY ANY LIMITATIONS]

[ ] My Agent may NOT consent to: [SPECIFY]

[ ] No limitations — Agent has full authority as described above

PART 2: LIVING WILL / ADVANCE DIRECTIVE

If I am in any of the following conditions, I direct my healthcare providers and Agent to follow these instructions:

END-OF-LIFE SITUATIONS

Terminal Condition (incurable illness with no reasonable expectation of recovery and death is imminent):

[ ] Continue all treatment. I want all available medical treatment to prolong my life as long as possible.

[ ] Discontinue life-sustaining treatment. I do NOT want my life prolonged by artificial means. Provide comfort care only.

[ ] Limited treatment. Try treatment for [__ days/weeks], then discontinue if no improvement. Provide comfort care.

Permanent Unconsciousness / Persistent Vegetative State (no reasonable expectation of regaining consciousness):

[ ] Continue all treatment.

[ ] Discontinue life-sustaining treatment. Provide comfort care only.

[ ] Limited treatment for [__ days/weeks], then discontinue.

Advanced Dementia (unable to recognize family, communicate, or perform self-care with no expectation of improvement):

[ ] Continue all treatment including hospitalization and artificial nutrition.

[ ] Comfort care only. Do not hospitalize; provide pain management and comfort measures.

[ ] Agent decides based on circumstances.

SPECIFIC TREATMENT PREFERENCES

For each treatment below, indicate your preference:

Treatment	Want	Do NOT Want	Agent Decides
CPR (Cardiopulmonary Resuscitation)	[ ]	[ ]	[ ]
Mechanical Ventilator (Breathing Machine)	[ ]	[ ]	[ ]
Artificial Nutrition (Feeding Tube)	[ ]	[ ]	[ ]
Artificial Hydration (IV Fluids)	[ ]	[ ]	[ ]
Dialysis (Kidney Machine)	[ ]	[ ]	[ ]
Blood Transfusions	[ ]	[ ]	[ ]
Antibiotics (for infections)	[ ]	[ ]	[ ]
Surgery	[ ]	[ ]	[ ]

Pain Management:

[ ] I want all available pain medication, even if it may hasten my death or reduce consciousness.

[ ] I want pain management but prefer to remain as alert as possible.

[ ] Agent decides based on my condition.

ORGAN & TISSUE DONATION

[ ] I WISH to donate my organs and tissues for transplant, therapy, research, or education.

[ ] I wish to donate ONLY the following: [SPECIFY — e.g., "eyes and kidneys only"]

[ ] I do NOT wish to donate any organs or tissues.

[ ] Agent decides.

DISPOSITION OF REMAINS

[ ] I wish to be cremated.

[ ] I wish to be buried at [CEMETERY / LOCATION].

[ ] I have pre-arranged services with [FUNERAL HOME NAME].

[ ] Agent decides.

PART 3: HIPAA AUTHORIZATION

I authorize my Healthcare Agent (and Alternates, if serving) to access all of my protected health information under the Health Insurance Portability and Accountability Act (HIPAA) and any applicable state privacy laws. This includes the right to:

- Receive, review, and obtain copies of my medical records;
- Discuss my condition and treatment with healthcare providers;
- Access billing and insurance information;
- Make decisions about disclosure of health information to others.

This authorization remains effective even after my incapacity or death.

PART 4: ADDITIONAL INSTRUCTIONS

[USE THIS SPACE FOR ANY PERSONAL WISHES, VALUES, OR INSTRUCTIONS NOT COVERED ABOVE — e.g., religious preferences, specific doctors, desire to die at home, specific comfort measures, music preferences during end-of-life care, etc.]

_____

_____

_____

PART 5: GENERAL PROVISIONS

(a) Effective Date. This Directive becomes effective when I am unable to make or communicate my own healthcare decisions, as determined by my attending physician.

(b) Revocation. I may revoke this Directive at any time by oral or written notice to my Agent or healthcare provider, or by executing a new Directive.

(c) Governing Law. This Directive shall be governed by the laws of the State of [STATE].

(d) Copies. A copy of this document shall have the same force and effect as the original.

(e) Agent's Liability. My Agent shall not be liable for any decisions made in good faith under this Directive.

(f) Physician's Compliance. If my physician is unwilling to honor my wishes expressed herein, I direct that my care be transferred to a physician who will comply.

EXECUTION

I sign this document voluntarily, of my own free will, after careful consideration.

Principal:

Signature: _____

Printed Name: [FULL LEGAL NAME]

Date: _____

WITNESS ATTESTATION

We declare that the person who signed this document appeared to be of sound mind, signed voluntarily, and was not under duress or undue influence. We are each at least 18 years of age and are not: (1) the designated Healthcare Agent, (2) a healthcare provider currently treating the Principal, or (3) an employee of such provider.

Witness 1:

Signature: _____

Printed Name: [FULL LEGAL NAME]

Address: [ADDRESS]

Date: _____

Witness 2:

Signature: _____

Printed Name: [FULL LEGAL NAME]

Address: [ADDRESS]

Date: _____

NOTARIZATION

State of [STATE] County of [COUNTY]

On [DATE], before me personally appeared [PRINCIPAL NAME], known to me to be the person who signed this document, and acknowledged that it was signed voluntarily.

Notary Public: _____

This Medical Power of Attorney & Healthcare Directive template is provided by ClearLegalTips.com for general informational purposes only. It does not constitute legal advice. Healthcare directive laws vary significantly by state — many states have specific statutory forms that may be required for legal validity. Some states combine all advance directive documents; others require separate forms. Consult a licensed attorney or your state's department of health for state-specific requirements.

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