DURABLE POWER OF ATTORNEY
(WITH HEALTH CARE POWERS ONLY)

NOTICE: **The powers granted by this document are broad and sweeping. If you have any questions about these powers, obtain competent legal advice. Free legal information regarding construction of the powers granted by this document and completion of this form may be obtained by calling the Legal Services Developer, Aging Services, Oklahoma Department of Human Services, (405) 522-3069, or your local legal aid or legal services office. This document authorizes your agent to make medical and other health care decisions for you. You may revoke this power of attorney if you later wish to do so.**

I _____
(insert name and address)

appoint _____
(insert name and address of the person appointed)
as my agent (attorney-in-fact) to act for me in any lawful way with respect to the following initialed subjects. If my agent is unable or unwilling to serve, I appoint _____
_____
(insert name and address)
as my alternate agent with the same authority.

Once effective pursuant to section III on the back of this form, this power of attorney will continue to be effective even though I become disabled, incapacitated or incompetent, and shall not be affected by lapse of time.

I. Grant of Health Care Powers

To grant all of the following powers, initial the line in front of (f) and ignore the lines in front of the other powers.

To grant one or more, but fewer than all, of the following powers, initial the line in front of each power you are granting. To withhold a power, do not initial the line in front of it. You may, but need not, cross out each power withheld.

1. If I am unable to decide or speak for myself, my agent has the power to:

Initial

_____ a. Make health and medical care decisions for me, including serving as my representative under the Oklahoma Do-Not-Resuscitate Act, but excluding signing an advance directive, making decisions reserved to a health care proxy under an advance directive, or other life-sustaining treatment decisions.

_____ b. Choose my health care providers.

_____ c. Choose where I live and receive care and support when these choices relate to my health care needs.

_____ d. Review my medical records and have the same rights that I would have to give my medical records to other people.

_____ e. Elect hospice treatment.

_____ f. All of the powers listed above.

You need not initial any other lines if you initial line (f).

2. It is my intention that my agent's acts on my behalf are to be honored by my family members and health care providers as an expression of my legal right to manage my health care. The directions and decisions of my agent are superior to and shall take precedence over any decision made by any member of my family. To the extent appropriate, my agent may discuss health care decisions with my family and others to the extent they are available.

II. Additional Guidance and Information

NOTE: **This section, while very helpful to your agent, is optional and choices may be left blank.**

a. My goals for my health care:_____
_____

b. My fears about my health care:_____
_____
_____

c. My spiritual or religious beliefs and traditions:_____
_____
_____

Patient Label
Patient Name:
MRN:
DOB:

d. My thoughts about how my medical condition might affect my family:_____

_____

_____

e. My thoughts about living and receiving health care at home versus in a nursing home or other institution:_____

_____

Special Instructions: On the following lines, you may give special instructions limiting or extending the powers granted to your agent._____

_____

_____

_____

_____

(Attach additional pages if needed.)

III. When Power Becomes Effective

Please initial one statement below regarding the effective date of this power of attorney.

Initial

____ This power of attorney is effective immediately and shall continue until it is revoked.

____ This power of attorney shall be effective when my attending physician determines that I am no longer able to manage my person. This determination shall be provided in writing and attached to this form.

I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party learns of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

Signed: _____

(principal's signature)

City County, and State of Residence

_____

The principal is personally known to me and I believe the principal to be of sound mind. I am eighteen (18) years of age or older. I am not related to the principal by blood or marriage, or related to the attorney-in-fact by blood or marriage. The principal has declared to me that this instrument is his power of attorney granting to the named attorney-in-fact the power and authority specified herein, and that he has willingly made and executed it as his free and voluntary act for the purposes herein expressed.

Witness: _____

Witness: _____

STATE OF OKLAHOMA)

) SS.

COUNTY OF_____)

Before me, the undersigned authority, on this_____day of_____, 20____, personally appeared _____(principal),_____(witness), and _____(witness), whose names are subscribed to the foregoing instrument in their respective capacities, and all of said persons being by me duly sworn, the principal declared to me and to the said witnesses in my presence that the instrument is his or her power of attorney, and that the principal has willingly and voluntarily made and executed it as the free act and deed of the principal for the purposes therein expressed, and the witnesses declared to me that they were each eighteen (18) years of age or over, and that neither of them is related to the principal by blood or marriage, or related to the attorney-in-fact by blood or marriage.

_____

Notary Public

My Commission Expires: _____

By accepting or acting under the appointment, the agent assumes the fiduciary and other legal responsibilities of an agent.

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Patient Label

Patient Name:

MRN:

DOB: