NOTICE TO THE INDIVIDUAL SIGNING THE POWER OF ATTORNEY FOR HEALTH CARE

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 on-line resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

WHAT ARE THE THINGS I WANT MY HEALTH CARE AGENT TO KNOW?

The selection of your agent should be considered carefully, as your agent will have the ultimate decision making authority once this document goes into effect, in most instances after you are no longer able to voice your own decisions. While the goal is for your agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your agent to make decisions to direct or refuse health care interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

(i) What is most important to you in your life?

(ii) How important is it to you to avoid pain and suffering?

(iii) If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?

(iv) Would you rather be at home or in a hospital for the last days or weeks of your life?

(v) Do you have religious, spiritual, or cultural beliefs that you want your agent and others to consider?

(vi) Do you have an existing advanced directive, such as a living will, that contains your specific wishes about health care that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.

WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

If there is ever a period of time when your physician determines that you cannot make your own health care decisions, or if you do not want to make your own decisions, some of the decisions your agent could make are to:

(i) talk with physicians and other health care providers about your condition.

(ii) see medical records and approve who else can see them.

(iii) give permission for medical tests, medicines, surgery, or other treatments.

(iv) choose where you receive care and which physicians and others provide it.

(v) decide to accept, withdraw, or decline treatments designed to keep you alive if you are near death or not likely to recover. You may choose to include guidelines and/or restrictions to your agent's authority.

(vi) agree or decline to donate your organs if you have not already made this decision yourself. This could include donation for transplant, research, and/or education. You should let your agent know whether you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State.

(vii) decide what to do with your remains after you have died, if you have not already made plans.

(viii) talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones).

Your agent is not automatically responsible for your health care expenses.

WHOM SHOULD I CHOOSE TO BE MY HEALTH CARE AGENT?

You can pick a family member, but you do not have to. Your agent will have the responsibility to make medical treatment decisions together with your physician and other professionals, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend, or other person who:

(i) is at least 18 years old;

(ii) knows you well;

(iii) you trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;

(iv) would be comfortable talking with and questioning your physicians and other health care providers;

(v) would not be too upset to carry out your wishes if you became very sick; and

(vi) can be there for you when you need it and is willing to accept this important role.

WHAT IF MY AGENT IS NOT AVAILABLE OR IS UNWILLING TO MAKE DECISIONS FOR ME?

If the person who is your first choice is unable to carry out this role when the time comes, you can choose one or more successor agents. Your successor agents function as back-up agents to your first choice agent and may act only one at a time and in the order you list them.

WHAT WILL HAPPEN IF I DO NOT CHOOSE A HEALTH CARE AGENT?

If you become unable to make your own health care decisions and have not named an agent in writing, your physician and other health care providers will ask a family member, friend, or guardian to make decisions for you. In Illinois, a law directs which of these individuals will be consulted. In that law, each of these individuals is called a "surrogate."

There are reasons why you may want to name an agent rather than rely on a surrogate:

(i) The person or people listed by this law may not be who you would want to make decisions for you.

(ii) Some family members or friends might not be able or willing to make decisions as you would want them to.

(iii) Family members and friends may disagree with one another about the best decisions.

(iv) Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

WHAT IF THERE IS NO ONE AVAILABLE WHOM I TRUST TO BE MY AGENT?

In this situation, it is especially important to talk to your physician and other health care providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes.

You can complete a living will. You can also write your wishes down and/or discuss them with your physician or other health care provider and ask him or her to write it down in your chart. You might also want to use written or on-line resources to guide you through this process.

WHAT DO I DO WITH THIS FORM ONCE I COMPLETE IT?

Follow these instructions after you have completed the form:

(i) Sign the form in front of a witness. See the form for a list of who can and cannot witness it.

(ii) Ask the witness to sign it, too.

(iii) There is no need to have the form notarized.

(iv) Give a copy to your agent and to each of your successor agents.

(v) Give another copy to your physician.

(vi) Take a copy with you when you go to the hospital.

(vii) Show it to your family and friends and others who care for you.

WHAT IF I CHANGE MY MIND?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one, including, but not limited to, your agents and your physicians.

WHAT IF I DO NOT WANT TO USE THIS FORM?

In the event you do not want to use the Illinois statutory form provided here, any document you complete must be executed by you, designate an agent authorized by law to serve as an agent, and state the agent's powers, but it need not be witnessed or conform in any other respect to the statutory health care power.

If you have questions about the use of any form, you may want to consult your physician, other health care provider, and/or an attorney.

My Power of Attorney for Health Care

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEATH CARE. (You must sign this form and a witness must also sign it before it is valid)

My name: Joe Client

My address: Anywhere, Illinois

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT (an agent is your personal representative under state and federal law, but your physician or health care provider cannot be designated as your agent):

Agent name: My Brother

Agent address:
Agent phone number:

SUCCESSOR HEALTH CARE AGENT(S) (optional):

If the agent I selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names):

Agent name: My sister

Agent address:
Agent phone number:

MY AGENT CAN MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING:

(i) Deciding to accept, withdraw or decline treatment for any physical or mental condition of mine, including life-and-death decisions.

(ii) Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.

(iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

(iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue or body donation, autopsy, cremation, and burial.

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

I AUTHORIZE MY AGENT TO

(please check any one box):

_____ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

(If no box is checked, then the box above shall be implemented.)

OR

_____ Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements.

SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES (optional):

_____ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life.

_____ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

MY AGENT'S ADDITIONAL POWERS:

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.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically in this form.

My signature: _____

Joe Client, Principal

Today's date:

HAVE YOUR WITNESS AGREE TO WHAT IS WRITTEN BELOW, AND THEN COMPLETE THE SIGNATURE PORTION:

I am at least 18 years old. (check one of the options below):

_____ I saw the principal sign this document, or

_____ the principal told me that the signature or mark on the principal signature line is his or hers.

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, mental health service provider, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

_____

_____

Witness Name

_____

Witness Street Address

_____

Witness City and State

This document was prepared by:

Power of Attorney for Health Care
of
Joe Client

I, Joe Client, 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 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.

Article 1
Recitals

Section 1.1 Designation of Agent

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: My Brother

Address:
Phone:

If My Brother is unwilling or unable to serve, I designate the individuals in the order listed below as alternate Agents to exercise the powers and discretions set forth in this instrument.

Name: My sister

Address:
Phone:

Section 1.2 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.

Section 1.3 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.

Section 1.4 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.

Article 2
Health and Personal Powers

Section 2.1 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.

Section 2.2 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.

Section 2.3 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.

Section 2.4 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.

Section 2.5 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.

Section 2.6 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.

Section 2.7 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.

Section 2.8 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.

Section 2.9 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.

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.

Legal and Administrative Powers and Provisions

Section 2.10 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.

Section 2.11 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.

Section 2.12 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.

Section 2.13 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.

Section 2.14 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.

Section 2.15 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.

Section 2.16 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.

Section 2.17 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.

Section 2.18 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 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:

_____

Joe Client, Principal

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 Name

_____

Witness Street Address

_____

Witness City and State