DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND/OR HEALTH CARE DIRECTIVE OF

(Print your full legal name here) _____

(Address, City, State, Zip)_____

(Pronouns and chosen name)_____

PART 1 - DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(If you *DO NOT WISH* to name someone to serve as your decision-making Agent, mark an "X" through Part 1 on pages 1 and 2 and continue on to Part 2.)

1. **Selection of Agent**. I, (your name printed) _____, currently a resident of _____ County, Missouri, appoint the following person as my true and lawful attorney-in-fact ("Agent"):

Name: _____

Address: _____

_____

Phone(s): 1st _____ 2nd _____

2. **Alternate Agent**. If my Agent resigns or is not able or available to make health care decisions for me, or if an Agent named by me is divorced from me or is my spouse and legally separated from me, I appoint the following persons in the order named below to serve as my alternate Agent and to have the same powers as my Agent:

First Alternate Agent:

Name: _____

Address: _____

_____

Phone(s): 1st _____

2nd _____

Second Alternate Agent:

Name: _____

Address: _____

_____

Phone(s): 1st _____

2nd _____

3. **Durability**. This is a Durable Power of Attorney, and the authority of my Agent, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

4. **Effective Date as to Health Care Decision Making**. This Durable Power of Attorney is effective as to health care decision making when I am incapacitated and unable to make and communicate a health care decision as certified by ***(check one of the following boxes):*** ☐ one physician **OR** ☐ two physicians.

5. **Agent's Powers**. I grant to my Agent full authority as to health care decision making to:

A. Give consent to prohibit or withdraw any type of health care, long-term care, hospice or palliative care, medical care, treatment, or procedure, either in my residence or a facility outside of my residence, even if my death may result, including, but not limited to, an out-of-hospital do-not-resuscitate order, with the following specific authorization ***(initial one of the following boxes to state your choice):***

_____ **Initials** I wish to AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

_____ **Initials** OR I DO NOT AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water);

B. Make all necessary arrangements for health care services on my behalf and to hire and fire medical personnel responsible for my care;

C. Move me into, or out of, any health care or assisted living/residential care facility or my home (even if against medical advice) to obtain compliance with the decisions of my Agent;

D. Take any other action necessary to do what I authorize here, including, but not limited to, granting any waiver or release from liability required by any health care provider and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney for Health Care;

E. Receive information regarding my health care, obtain copies of and review my medical records, consent to the disclosure of my medical records, and act as my "personal representative" as defined in the regulations [45 C.F.R. 164.502(g)] enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

6. **Effective Date as to Other Authority.** In addition to the powers set forth above, I authorize effective upon my signature and without the need for a physician's certification of incapacity that my Agent be authorized to have one or more of the following powers ***(initial your desired choices):***

_____ **Initials** Determine what happens to my body after my death (authority for right of sepulcher);

_____ **Initials** Give consent after my death to an autopsy or postmortem examination of my remains;

_____ **Initials** Delegate health care decision-making power to another person ("Delegee") as selected by my Agent, and the Delegee shall be identified in writing by my Agent;

With respect to anatomical gifts of my body or any part (*i.e.,* organs or tissues), please initial your desired choice below:

_____ **Initials** **AUTHORIZATION OF ANATOMICAL GIFTS**. I wish to AUTHORIZE my Agent to make an anatomical gift of my body or part (organ or tissue).

My donations are for the following purposes: (check one)	GIFT SPECIFICATIONS: (check one)
☐ Transplantation ☐ Therapy ☐ Research ☐ Education ☐ All the above	I would like to donate ☐ Any needed organs and tissues, as allowed by law. ☐ Any needed organs and tissues as allowed by law, with the following restrictions:

_____ **Initials** **PROHIBITION OF ANATOMICAL GIFTS**. I DO NOT AUTHORIZE my Agent to make an anatomical gift of my body or any part (organ or tissue).

7. **Agent's Financial Liability and Compensation**. My Agent, acting under this Durable Power of Attorney for Health Care, will incur no personal financial liability. My Agent shall not be entitled to compensation for services performed under this Durable Power of Attorney for Health Care, but my Agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions hereof.

PART 2 - HEALTH CARE DIRECTIVE

(If you *DO NOT WISH* to make a health care directive but only wish to have an Agent make your decisions without the directive, be sure that you have completed Part 1 on pages 1 and 2, mark an "X" through Part 2 on pages 2 and 3, and continue to Part 3.)

1. I make this HEALTH CARE DIRECTIVE ("Directive") to exercise my right to determine the course of my health care and to provide clear and convincing proof of my choices and instructions about my treatment.

2. If I am persistently unconscious or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, I direct that all of the life-prolonging procedures that I have initialed below be withheld or withdrawn.

____ Initials	**artificially supplied nutrition and hydration (including tube feeding of food and water)**		
____ Initials	**surgery or other invasive procedures**	____ Initials	**heart-lung resuscitation (CPR)**
____ Initials	**antibiotics**	____ Initials	**dialysis**
____ Initials	**mechanical ventilator (respirator)**	____ Initials	**chemotherapy**
____ Initials	**radiation therapy**		
____ Initials	**other procedures specified by me (insert) _____**		
____ Initials	**all other "life-prolonging" medical or surgical procedures that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury**		

3. However, if my physician believes that any life-prolonging procedure may lead to a recovery significant to me as communicated by me or my Agent to my physician, then I direct my physician to try the treatment for a reasonable period of time. If it does not cause my condition to improve, I direct the treatment to be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

4. If I have chosen to not have life-prolonging procedures (any and all of the boxes above having been checked), **(please check one of the following boxes)**: ☐ I do want OR ☐ I do not want palliative care; hospice care; medication for anxiety, pain, and/or discomfort; ice chips; mouth swabs; and any other measures to keep me comfortable.

5. If I have already consented to be on the Missouri organ and tissue donor registry or my Agent has authorized the donation of my organs or tissues, I realize it may be necessary to maintain my body artificially after my death until my organs or tissues can be removed.

IF I HAVE NOT DESIGNATED AN AGENT IN THE DURABLE POWER OF ATTORNEY, PART 2 OF THIS DOCUMENT IS MEANT TO BE IN FULL FORCE AND EFFECT AS MY HEALTH CARE DIRECTIVE.

PART 3 - GENERAL PROVISIONS INCLUDED IN THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE

1. Relationship Between Durable Power of Attorney for Health Care and Health Care Directive. If I have executed both the Durable Power of Attorney for Health Care and Health Care Directive, I encourage my Agent to:

A. First, follow my choices as expressed in the above Directive or otherwise from knowing me or having had various discussions with me about making decisions regarding life-prolonging procedures.

B. Second, if my Agent does not know my choices for the specific decision at hand, but my Agent has evidence of my preferences, my Agent can determine how I would decide. My Agent should consider my values, religious beliefs, past decisions, and past statements. The aim is to choose as I would choose, *even if it is not what my Agent would choose for themself.*

C. Third, if my Agent has little or no knowledge of choices I would make, then my Agent and the physicians will have to make a decision based on what a reasonable person in the same situation would decide. I have confidence in my Agent's ability to make decisions in my best interest if my Agent does not have enough information to follow my preferences.

D. Finally, if the Durable Power of Attorney for Health Care is determined to be ineffective, or if my Agent is not able to serve, the Health Care Directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

2. Protection of Third Parties Who Rely on My Agent. No person who relies in good faith upon any representations by my Agent or Alternate Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

3. Revocation of Prior Durable Power of Attorney for Health Care or Health Care Directive. I revoke any prior living will, declaration, or health care directive executed by me. If I have appointed an Agent in a prior durable power of attorney, I revoke any prior health care durable power of attorney or any health care terms contained in that other durable power of attorney and intend that this Durable Power for Attorney for Health Care (if completed) and this Health Care Directive (if completed) replace or supplant earlier documents or provisions of earlier documents.

4. Validity. This document is intended to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be as valid as the original.

IF YOU HAVE COMPLETED THE ENTIRE DOCUMENT OR ONLY THE HEALTH CARE DIRECTIVE (PART 2), YOU MUST SIGN THIS DOCUMENT IN THE PRESENCE OF TWO WITNESSES.

IN WITNESS WHEREOF, I signed this document on _____(month, date),_____(year).

_____
Signature
Printed Name: _____

WITNESSES: The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least eighteen years of age.

Signature	_____	Signature	_____
Print Name	_____	Print Name	_____
Address	_____	Address	_____
	_____		_____

NOTARY ACKNOWLEDGMENT
(Only required if Part 1 or entire document completed.)

STATE OF MISSOURI)
) SS
COUNTY OF _____)

On this _____ day of _____ (month), _____ (year), before me personally appeared _____ _____, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County or City and state aforementioned, on the day and year first above written.

_____

_____, Notary Public
(Name Printed)