DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I, (principal)_____designate and appoint: (Agent Name):_____ of (Address)_____
Phone:_____ Cell Phone: _____

to be my agent for health care decisions and pursuant to the language stated below, on behalf to:

(1) Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, and to make decisions about organ donation, autopsy and disposition of the body;

(2) Make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care as the agent shall deem necessary for my physical, mental and emotional well-being; and

(3) Request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute any releases of other documents that may be required in order to obtain such information.

In exercising the grant of authority set forth above my agent for health care shall (insert any special instructions:_____

LIMITATIONS OF AUTHORITY
(1) The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for health care decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.

(2) The agent shall be prohibited from authorizing consent for the following items (if any):
_____

(3) This durable power of attorney for health care decisions shall be subject to the additional following limitations (if any): _____

EFFECTIVE TIME
This power of attorney for health care decisions shall become effective immediately and shall not be affected by my subsequent disability or incapacity or upon the occurrence of my disability or incapacity.

REVOCATION
Any durable power of attorney for health care decisions I have previously made is thereby revoked. *If the agent or an alternate agent designated in this Directive is my spouse, and our marriage is thereafter dissolved, such designation shall be thereupon revoked.* (This durable power of attorney for health care decisions shall be revoked by an instrument in writing executed, witnessed or acknowledged in the same manner as required herein or set out in another manner of revocation, if desired.)

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If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this Directive, such persons to serve in the order listed below:

A. First Alternate Agent Name: _____
Address: _____
Telephone Number: _____

B. Second Alternate Agent Name: _____
Address:_____
Telephone Number: _____

EXECUTION

Executed this _____, at _____, Kansas _____

Principal Signature: _____ Date: _____

This document must be: (1) witnessed by two individuals of lawful age who are not the agent, not related to the principal by blood, marriage or adoption, not entitled to any portion of principal's estate and not financially responsible for principal's health care: **OR** (2) acknowledged by a notary public.

_____	_____
1. Witness Printed Name	Signature
_____	_____
Address	Phone number
_____	_____
2. Witness Printed Name	Signature
_____	_____
Address	Phone number

(or)

STATE OF _____) COUNTY OF _____)

This instrument was acknowledged before me on_____(date) by

_____(name of person)_____(signature of notary public)

(Seal, if any)

My appointment expires: _____ Copies