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STATE OF ALABAMA)
)
COUNTY OF)

DURABLE HEALTH CARE POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS THAT I, _____, of _____, City of _____, County of _____, Alabama, hereby make, constitute and appoint _____, whose address is _____, to act as my agent or attorney in fact, to make health care and related personal decisions for me as authorized in this document. Should _____ for any reason be unable or unwilling to act, temporarily or permanently, then I appoint _____, of _____ as such agent/attorney in fact, with the same authority.

By this document I intend to create a durable power of attorney upon, and only during, any period of incapacity in which, in the opinion of my health care agent/attorney in fact, after consultation with my health care providers, I am unable to make or communicate a choice regarding a particular health care decision.

This document is intended to complement and supplement any Advance Health Care Directive and/or Durable Power of Attorney for financial matters that I may have executed or may execute in the future.

It is my desire to receive appropriate medical treatment so long as there is a reasonable hope of recovery, but I do not want my life artificially extended beyond any reasonable hope of recovery to a meaningful quality of life and I do not want to prolong the dying process.

I do not intend by this document to authorize or request euthanasia or assisted suicide but to avoid being unwillingly sustained in a condition that is only a semblance of life; or to be allowed to endure pain for which there is treatment available, whether or not recovery is possible.

I grant to my agent full power to make decisions for me regarding my health care. In exercising his/her authority, my agent shall attempt to communicate with me regarding my wishes if I am able to communicate in any way. If my agent cannot determine the choice I want made, then (s)he shall make the choice for me based upon what (s)he believes I would do if I were able, or if unable to so determine, then based upon what (s)he believes to be my best interests.

I intend the power given to be as broad as possible, except for any limitations in my Advance Directives or set out hereinafter. Accordingly, unless so limited, my agent is authorized:

To consent to, refuse or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medications and use of mechanical or other procedures affecting bodily functions; including, without limitation, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

- To have access to and have the right to disclose medical reports, records and

information to the extent that I would myself;

- To authorize admission to or discharge from any hospital, residential care or related facility, even against medical advice;
- To contract for health care or related services, without the agent incurring personal liability therefore;
- To hire and fire medical, social service or related personnel responsible for my care;
- To authorize or refuse to authorize any medication or procedure to relieve pain, even though such use may lead to temporary discomfort or addiction, or inadvertently hasten the moment of death;
- To make anatomical gifts of part of all of my body for medical purposes,
- To authorize an autopsy and direct disposition of my remains, to the extent permitted by law, and
- To take any other action necessary to effectuate the intent and purpose of this broad grant of powers, including, without limitation, granting any waiver of release from liability required by any health care provider or related agency, and
- To sign any document relative to health care in any way whatsoever and pursuing legal action in my name at the expense of my estate, should that be necessary to enforce compliance with my wishes as determined by my agent pursuant to the authority given herein.

Without in any way limiting the broad powers herein granted, I express the hope that, circumstances permitting, my agent will consult family and friends for their advice and support in arriving at what may be difficult decisions; but the final decisions shall be that of my agent.

No person who relies in good faith upon any representation of my agent or successor agent shall be liable to me, my estate, my heirs or assignees, for recognizing the agent's authority.

Although no compensation of my agent is contemplated, (s)he shall be entitled to reimbursement of any and all reasonable expenses incurred as a result of carrying out any provision of this document.

Invalidity of one or more powers shall not invalidate any others.

I am in full control of my mental faculties and I understand the contents of this document and the effect of this grant of powers to my agent.

Dated this _____ day of _____, _____. _____

,Grantor

WITNESSES

I believe the Grantor to be of sound mind and able to make decisions of this kind. I did not sign his/her name and I am not the health care agent. I am not related to the Grantor by blood, adoption or marriage, and not entitled to any part of his/her estate. I am at least 19 years old and am not directly responsible for his/her medical care or expenses.

_____	_____	_____
Signature of Witness	Name of Witness	Date

_____	_____	_____
Signature of Witness	Name of Witness	Date

ATTESTATION

I, the undersigned authority in and for said County in said State, hereby certify that _____, whose name is signed to the foregoing Durable Health Care Power of Attorney, and who is known to me, acknowledged before me on this day that, being informed of the contents of the said document, (s)he executed the same voluntarily, before the witnesses whose names appear above, on the day the same bears date.

Given under my hand this _____ day of _____, _____.

_____
Notary Public

My commission expires:
_____

SIGNATURES OF AGENTS

I, _____, am willing to serve as Health Care Agent.

Signature: _____ Date: _____

I, _____, am willing to serve as Health Care Agent if the first-named Agent cannot serve.

Signature: _____ Date: _____