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

(Print full name here) ________________________________

(Address, City, State, Zip) ________________________________

PART I. 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 I on pages 1 & 2 and continue on to Part II.)

1. **Selection of Agent**. I, ______________________________, 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**. This Durable Power of Attorney is effective 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 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 indicate 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");

F. Execute an outside-the-hospital do not resuscitate order form as my patient's representative;

G. In addition to the powers set forth above, I authorize my Agent to do one or more of the following ***(initial your desired choices):***

______ Initials Determine what happens to my body after my death;

______ 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;

H. 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) I would like to donate
☐ Transplantation ☐ Therapy ☐ Research ☐ Education ☐ All the above	☐ 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).

6. **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 II. 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 I on pages 1 & 2, mark an "X" through Part II on pages 2 & 3 and continue to Part III.)

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 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 II OF THIS DOCUMENT IS MEANT TO BE IN FULL FORCE AND EFFECT AS MY HEALTH CARE DIRECTIVE.

PART III. 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 himself or herself.*

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 DIRECTIVE (PART II), 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 I 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)

Continued from page 4 (prior to detachable insert)

Section 4 (Page 1). **Effective Date**: The Agent designated in your Durable Power of Attorney for Health Care may only act after one or two physicians determine that you lack capacity to make your health care decisions. Please indicate whether you want one or two physicians to determine when you are incapacitated. If you fail to specify, then the law presumes that you want two. Please remember that in some parts of the state and in certain health care facilities during after-hours emergencies, it may be difficult to find a second physician to determine capacity in order to have someone advocate for your health care.

Section 5 (Page 1). **Agent's Powers**: Some of the listed powers are self-explanatory and do not require you to choose from options but give your Agent the power to advocate for treatment and care for you, as well as make necessary decisions to provide informed consent for your medical care. Other listed powers require for you to choose from some options. The following instructions are for the subsections that require you to choose your option.

In Subsection 5. A. (Page 1), please indicate your choice by checking one of the two boxes indicating whether or not you authorize your Agent to withhold or withdraw artificially-supplied nutrition or hydration.

In Subsection 5.G. (Page 2), you may specify certain powers for your Agent as follows:

- ✓ To have the Right of Sepulcher over your body to be designated "next of kin" under Missouri law to have custody and control for the disposition of your body.
- ✓ To consent to an autopsy after your death.
- ✓ To delegate decision-making power to another person. This can be useful if your Agent might be temporarily unavailable.

In Subsection 5.H. (Page 2), you may choose, by checking the shaded box, to authorize anatomical gifts with a range of stated options to further check off, or you may choose to prohibit such anatomical gifts by checking the second shaded box.

Be sure to initial the bottom of pages 1, 2 and 3 of the form.

Instructions for Part II – HEALTH CARE DIRECTIVE (Pages 2-3)

If you choose to provide directions to your Agent or your health care providers about what life-prolonging procedures you want or do not want if you are in a persistently unconscious or terminally ill condition, please complete Part II. If you choose not to provide direction to your Agent or your health care providers, mark an "X" through Part II on pages 2 and 3 and proceed to Part III to sign your form.

Section 1 (Page 2) indicates your intent for the directive under Missouri law to provide clear and convincing proof of your choices and instructions about life-prolonging treatment.

Section 2 (Page 3) indicates that life-prolonging procedures are to be withheld or withdrawn only under two conditions: either you are in a persistently unconscious condition with no reasonable chance of medical recovery, or you are at the end-stage of a terminal condition. Where the line is drawn on such issues often depends upon what your medical providers determine and tell you. Your Agent may find other providers who have other opinions.

Certain life-prolonging procedures are listed for you to indicate that you choose to withhold or withdraw by putting your initials in the shaded boxes when you are in a persistently unconscious condition or you are at the end-stage of a terminal condition. If you know of a procedure that you do not want but it is not listed, you can specify it by writing its name in the blank line given.

Section 3 (Page 3) indicates that if providing any life-prolonging procedures might result in a recovery that you define as reasonable, then you want that procedure done. This sec-

tion also allows you to choose to do any of the initialed life-prolonging procedures if the reason for doing them is to relieve your pain or provide comfort to you in addition to prolonging your life.

Section 4 (Page 3) only applies if you have consented to make anatomical gifts of your organs or tissues in order to carry out your choice to do them.

Instructions for Part III – GENERAL PROVISIONS APPLICABLE TO THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE (Pages 3-4)

Part III must be completed for the Durable Power of Attorney for Health Care (Part I) and the Health Care Directive (Part II) to be effective. Some of the sections are self-explanatory and a few are discussed below.

Section 1. Relationship Between Durable Power of Attorney for Health Care and Health Care Directive (Pages 3-4). If you have completed both the Durable Power of Attorney for Health Care (Part I) and the Health Care Directive (Part II) or you have just completed the Durable Power of Attorney for Health Care (Part I), then this section sets out steps for your Agent to consider and follow in making decisions about life-prolonging procedures for you.

A. First, follow your choices as expressed in your Directive (if you completed it) or otherwise from knowing you or having had various discussions with you about making decisions regarding life-prolonging procedures.

B. Second, if your Agent does not know your choices for the specific decision at hand, but your Agent has evidence of what you might want, your Agent can try to determine how you would decide. This is called *substituted judgment,* and it requires your Agent to imagine himself or herself in your position. Your Agent should consider your values, religious beliefs, past decisions, and past statements you have made. The aim is to have your Agent choose as you would probably choose, *even if it is not what your Agent would choose for himself or herself.*

C. Third, if your Agent has very little or no knowledge of choices that you would want, then your Agent and the doctors will have to make a decision based on what a reasonable person in the same situation would decide. This is called making decisions in your *best interest.* You should have confidence in your Agent's ability to make decisions in your best interest if your Agent does not have enough information to follow your preferences or use substituted judgment. If this is the case, you authorize your Agent to make decisions which might even be contrary to your Directive in his or her best judgment.

D. Finally, if the durable power of attorney is determined to be ineffective, or if your Agent (or your named alternate) is not able to serve, the Directive (if you have completed it) is intended to be used on its own as firm instructions to your health care providers regarding life-prolonging procedures.

Section 3 (Page 4). Revocation of Prior Durable Power of Attorney for Health Care or Prior Health Care Directive. If you have completed one or both of Parts I and II, you are replacing and supplanting any durable power of attorney with health care terms or any earlier health care directive or living will. You should give copies of your most recent completed forms to your Agent and alternate, your physician and other health care providers, and your family members.

Section 4. Validity (Page 4). This document will be considered valid in Missouri and should be recognized in other states and countries on a temporary basis when you are traveling. If you change your residency, you should complete the form that your new home state recognizes. In recognition that the documents need

to be given to many people, including health care providers, copies are considered as valid as the original.

Signature (Page 4). You must sign the form in the presence of two witnesses if you complete Part II and a notary public if you complete Part I (or both Part I and Part II).

Witnesses (Page 4). Because Missouri requires clear and convincing evidence of wishes expressed in the Health Care Directive (Part II), two witnesses are required. Thus, witnesses are required if both the Durable Power of Attorney for Health Care (Part I) and Health Care Directive (Part II) are completed or only the Health Care Directive (Part II). It is suggested that the witnesses not be related to you and be at least 18 years of age.

NOTARY ACKNOWLEDGMENT (Page 4). The notary acknowledgment is required by Missouri law if you appoint an agent and complete a Durable Power of Attorney for Health Care (Part I), or if you complete both Part I and Part II.

FINAL INSTRUCTIONS

After you have completed the form and indicated your choices, you should do the following:

☞ Make copies of the form for your Agent and any alternates, your physician (take them to your next appointments), and your health care providers when you are admitted (e.g., hospitals, clinics, nursing homes, assisted living facilities, hospice and palliative care providers, and home health agencies). You will be asked about them each time you are admitted, and you should give them new copies each time you change your form.

☞ Discuss, discuss, discuss with your family, your Agent, your physicians, and your health care providers your choices, wishes, and views about your health conditions, the treatments that you prefer, the care or treatment that you want to avoid, and what choices you would want made if life-prolonging procedures are proposed for you when you are persistently unconscious or when you are at the end stage of a serious incapacitating or terminal illness or condition.

☞ If you have choices that you want followed not only about life-prolonging procedures but also about other end-of-life considerations, please discuss what you want with your family, your physicians, your clergy, and your agents. You may obtain assistance with such planning from lawyers who can help you clarify your wishes in writing.

☞ After you have completed the Durable Power of Attorney for Health Care Form and given it to your agent, you should tell your agent that you will make your own decisions until you are certified as being incapacitated. After you have been certified as incapacitated, tell your agent that he or she will be asked to make any treatment decisions for you. When your agent signs your consent and other forms to carry out your choices, you should tell your agent to sign your name first and sign his or her name afterwards to indicate that your agent is signing for you using your Durable Power of Attorney for Health Care. For example, your agent would sign "John H. Doe, by Sally I. Smith, POA."

Instructions for HIPAA Privacy Authorization Form

You are entitled to keep your health information private. The HIPAA Privacy Authorization Form should be completed if you would like some person other than yourself to have access to your medical records and information. This form gives your health care providers written authorization to release your health information to the persons you have named.

Since a Durable Power of Attorney for Health Care is only effective after you have lost your capacity to make or communicate decisions and does not authorize release of medical information to the person named while you remain competent, it is then necessary to complete and sign the HIPAA Privacy Authorization Form.

You may complete a HIPAA Privacy Authorization Form whether or not you have a Durable Power of Attorney for Health Care. This HIPAA Authorization Form in this booklet is to be used along with the Durable Power of Attorney for Health Care form.

In **Section 1,** insert the name of your Agent named in your Durable Power of Attorney for Health Care.

In **Section 2(a),** indicate what time period is covered by the authorization, either with the specific dates or by checking the box that permits the release of medical information for all past, present, and future periods.

In **Section 2(b)**, check the box if you want to include all of your medical records.

In **Section 3(a),** check the box to indicate whether you want your complete health record, which includes records related to mental health, communicable diseases, HIV or AIDS and the treatment of alcoholism or drug abuse, to be released.

In **Section 3(b)**, check the box to indicate which records you want to exclude, if you want any excluded. Please note that if you do not want to authorize the release of your complete health record, you must indicate with a check which records you want excluded.

In **Section 4,** insert the name of the person or persons and relationship to you to whom you give permission to receive your medical information in addition to the Agent named in your Durable Power of Attorney for Health Care. Oftentimes people want other family members or friends to find out how you are doing in addition to your Agent. It is recommended that you name the Alternate Agents from your Durable Power of Attorney for Health Care.

In **Section 6,** fill in the date if you want this authorization to expire; otherwise, the authorization will remain in effect until nine (9) months after your death.

Please read **Sections 5, 7, 8 and 9** before signing your name and dating the form.

After you have completed the HIPPA Privacy Authorization Form, detach, make copies and give copies to your health care providers.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (“PHI”) described below to my agent identified in my durable power of attorney for health care named ____.

2. Authorization for release of PHI covering the period of health care (check one)
   a. ☐ from (date) _________________ - to (date)_______________________ OR
   b ☐ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one)**:**
   a. ☐ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR
   b. ☐ my complete health record *with the exception of the following information* (check as appropriate):
      - ☐ Mental health records
      - ☐ Communicable diseases (including HIV and AIDS)
      - ☐ Alcohol/drug abuse treatment
      - ☐ Other (please specify): ____ .

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

   Name ____ Relationship _____________________

   Name ____ Relationship _____________________

   Name ____ Relationship _____________________

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or __________________________________, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ Date: _________________________

Signature of Patient

Tear off, keep original, and give copies to your health care provider, agent and family members