POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

KNOW ALL MEN BY THESE PRESENTS, that I, _____ of _____ _____(the "Principal") hereby designate _____, my _____, as my attorney in fact ("Attorney"). I hereby give to my Attorney the power to make health care decisions on behalf of me and in my name as authorized in this document. In the event if my Attorney is unwilling or unable to serve, I further nominate _____ to serve as my Attorney.

Except as otherwise stated in this document, my Attorney shall have full power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. My Attorney shall also have the right to examine my medical records and to consent to disclosure of such records.

This power of attorney may be revoked by me at any time in any manner by which I am able to communicate my intent to revoke to my health care agent and my attending physician. If not revoked, this power of attorney comes into effect only when it is certified as stated hereunder that I am unable to make those health care decisions. My incapacity shall be deemed to exist when so certified in writing by two licensed physicians not related to either me or my Attorney. The said certificate shall state that I am unable, physically or mentally, in the judgment of said physician, to make those health care decisions for myself.

Notwithstanding anything to the contrary, I reserve the right to make any medical and other health care decisions for myself so long as I am able to consent with respect to a particular decision. In addition, no treatment may be given to me over my objection, and health care necessary to keep me alive may not be stopped if I object.

I hereby authorize all physicians who have treated, or will treat me, and all other providers of health care, including hospitals, to release to my Attorney all information contained in my medical records which my Attorney may request whether oral or written.

No person who relies in good faith upon the authority or any representations by my Attorney shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions by my Attorney.

I revoke any prior health care power of attorney.

Signed this _____ day of _____, 20_____

_____

signature

Witness's signature and addresses:

_____

signature

address:

_____

_____

_____

signature

address:

_____

_____

State of _____

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County of _____

On this ____ day of _____, _____, before me, the undersigned, a Notary Public in and for the State of _____, personally appeared _____ to me known to be the identical person named in and who executed the foregoing instrument, and acknowledged that he or she executed the same as his or her voluntary act and deed.

_____

Notary Public