

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
OF

Pursuant to the Arkansas Durable Power of Attorney for Health Care Act (Ark. Code Ann. § 20-13-104) (the “Act”), I hereby designate and appoint _____, my _____, as my agent, or attorney-in-fact, to make decisions regarding my health care during periods when my health care provider has determined that I lack capacity to decide for myself. Specifically, and not to limit any other rights prescribed under the Act, my attorney-in-fact shall have the power to have access to my medical records for treatment and payment decisions; to disclose medical records to others for purposes of treatment, payment, or health care operations; to employ and discharge physicians; to consent to or refuse to consent to medical procedures, including the withholding or withdrawal of life-sustaining treatment, and nutrition and hydration, according to my wishes expressed in my Declaration of Living Will, or, if my wishes are unclear under the then existing circumstances of my medical condition, then upon consideration of my best interests as determined by my physician in consultation with my agent, so long as any such consent or refusal to consent is in full accordance with the doctrines and teachings of the Holy Roman Catholic Church; to admit me to hospitals, including psychiatric hospitals, nursing homes, or hospice care; and to sign all appropriate forms, consents and releases in connection with any of said matters. Moreover, should there be any doubt as to the authority of my attorney-in-fact, I hereby designate my attorney-in-fact as my “Personal Representative” for the purposes of the federal Health Insurance Portability and Accountability Act of 1996 (referred to herein as “HIPAA”). Accordingly, my attorney-in-fact is authorized to request, receive and review any information, verbal or written, regarding my personal affairs or my physical or mental health, including, but not limited to, private, privileged, protected or personal health information as defined in HIPAA, and to execute any releases or other documents that may be required in order to obtain such information, and to disclose such information to such persons, organizations, firms or corporations as my Agent shall deem appropriate. I acknowledge that information disclosed by a health care provider or other entity covered by HIPAA may be redisclosed and may no longer be subject to the privacy rules provided by law (including 45 CFR § 164).

If _____ resigns, or is not able or available to make health care decisions for me, I appoint _____, my _____, as successor, with all of the rights and powers and authority herein stated. The term “health care” shall have the meaning set forth in Ark. Code Ann. § 20-13-104(c). This Durable Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity. This Durable Power of Attorney for Health Care shall be in addition to, and not in substitution or replacement of, any other Durable Power of Attorney executed by me for other purposes.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this ____ day of _____, ____.

SUBSCRIBED AND SWORN to before me this ____ day of _____, _____:

Notary Public

We, the undersigned witnesses, hereby certify that _____ signed the foregoing Durable Power of Attorney for Health Care in our presence, and we, at his request, in his presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that he appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that his signature was voluntary.

Signature _____

Signature _____

Printed Name _____

Printed Name _____

Address:

Address: