



INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

State Form 56184 (11-16)

Indiana State Department of Health – IC 16-36-1; IC 16-36-6

INSTRUCTIONS: See instructions on back.

Patient / Appointor Information		
Patient Last Name	Patient First Name	Patient Middle Initial
Patient Birthday (<i>mm/dd/yyyy</i>)	Medical Record Number of Healthcare Facility or Provider (<i>optional</i>)	Healthcare Facility or Provider (<i>optional</i>)
Appointment of Health Care Representative		
<p>I, being at least eighteen (18) years of age, of sound mind, and capable of consenting to my health care, hereby appoint the person(s) named below as my lawful health care representative in all matters affecting my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities, unless otherwise provided in this appointment. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation below supersedes (replaces) any prior named Health Care Representative(s).</p> <p>I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.</p> <p>I specify the following terms and conditions (<i>if any</i>):</p>		
Name of Representative Appointed	Address of Representative (<i>number and street, city, state, and ZIP code</i>)	Telephone Number of Representative
Signature of Patient / Appointor or Designee (<i>must be signed in the appointor's presence</i>)	Printed Name of Patient / Appointor or Designee	Date of Appointment (<i>mm/dd/yyyy</i>)
Signature of Witness	Printed Name of Witness	Date (<i>mm/dd/yyyy</i>)