LOUISIANA

HEALTH CARE POWER OF ATTORNEY

1. I, _____, hereby appoint:

_____ _____
Name Home Address

(_____)_____ _____
Home Telephone Number

(_____)_____ (_____)_____
Work Telephone Number Cell Telephone Number

as my agent to make health-care decisions for me if I become unable to make my own health-care decisions, as follows (initial one choice per option):

A. _____ I DO/ _____ I DO NOT grant my agent the power to: Grant, refuse, or withdraw consent on my behalf for any health care service, treatment or procedure, even though my death may ensue.

B. _____ I DO/ _____ I DO NOT grant my agent the power to: Authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service.

C. _____ I DO/ _____ I DO NOT grant my agent the power to: Contract on my behalf for any health-care related services or facility (without my agent incurring personal financial liability for such contracts) such as surgery, medical expenses and prescriptions.

D. _____ I DO/ _____ I DO NOT grant my agent the power to: Make decisions regarding surgery, medical expenses and prescriptions.

E. _____ I DO/ _____ I DO NOT grant my agent the power to: Prevent or limit reasonable communication, visitation, or interaction between me and a relative by blood, adoption or marriage, or another individual who has a relationship based on strong affection, specifically the following individuals:
_____, _____, or _____. The following individuals shall not be restricted from reasonable communication, visitation, or interaction with me.
_____, _____, or _____

2. If the person named as my agent is not available or is unable to act as my agent, I appoint the following person(s) to serve in the order listed below:

A.

_____ _____
Name Home Address

(_____)_____ _____
Home Telephone Number

(_____)_____ (_____)_____
Work Telephone Number Cell Telephone Number

B.

_____ _____
Name Home Address

(_____)_____ _____
Home Telephone Number

(_____)_____ (_____)_____
Work Telephone Number Cell Telephone Number

3. With this document, I authorize any person, organization, or entity involved with my health care to disclose and release to my agent any and all of my individually identifiable health information and medical records in accordance with HIPAA. I further authorize my agent to talk to health care personnel, get information, have access to medical records and sign forms necessary to carry out these decisions.

4. SPECIAL PROVISIONS AND LIMITATIONS.

I do NOT want the following treatments:
1._____
2._____
3._____
4._____

I DO want the following treatments:
1._____
2. _____
3._____
4._____

Other provisions and limitations:

5. No person who relies in good faith upon representations by my agent or alternate agent shall be liable to me, my estate, my heirs or assigns for recognizing the agent's authority.

6. The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect any others.

BY MY SIGNATURE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

I SIGN MY NAME TO THIS FORM ON _____, 20__.

at: _____.
(City, State)

_____
(Signature)

WITNESSES

The person who signed or acknowledged this document is personally known to me and I believe him/her to be of sound mind.

First Witness Signature: _____

Print Witness Name _____Date: _____

Second Witness Signature: _____

Print Witness Name: _____ Date: _____

NOTARIZATION (Optional)

STATE OF _____ PARISH OF _____

I, _____, a Notary Public in and for the State and Parish aforesaid, do hereby certify that _____, who personally came and appeared before me as the Principal, and executed the foregoing Durable Power of Attorney for Health-Care in said State and Parish, and acknowledged said Durable Power of Attorney for Health-Care as the Principal's voluntary act.

Witness my signature this _____ day of _____, 20__.

_____
NOTARY PUBLIC

LOUISIANA LIVING WILL DECLARATION

Declaration made this _____ day of _____, 20__.

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

If at any time I should have an incurable injury, disease or illness, or be in a continual profound comatose state with no reasonable chance of recovery, certified to be a terminal and irreversible condition by two physicians who have personally examined me, one of who shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized, and where the application of life-sustaining procedures would serve only to prolong artificially the dying process, I direct (initial one only):

_____ That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.

_____ That all life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I further direct that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed: _____

Print Name: _____

City, Parish and State of Residence_____

_____

WITNESSES

I declare that the person who signed this document is personally known to me, and that he or she appears to be of sound mind. I am at least 18 years of age and am not related to the person who signed this document by blood or marriage, or entitled to any portion of his/her estate under any will or by operation of law.

1. _____
Witness

_____
Address

_____
City State/Zip

2. _____
Witness

_____
Address

_____
City State/Zip

Wallet Card

It is essential that your health care provider know that you have executed an advance directive. Your treating physicians should be given a copy of the documents.

The wallet card is one way to do this. Fill out the card, sign, and date it. Then cut it out and carry it with you at all times. It may be helpful to laminate this wallet card.

Notice to Health Care Providers

☐ *I have executed a **Living Will***
☐ *I have executed a **Health Care Power of Attorney** and appointed:*

_____ *(Agent's Name)*

_____ *(Agent's Address)*

Phone: _(___)_____ (day) _(___)_____(eve.)
As my agent to make health and personal care decisions for me if I am unable to do so. He/she has a copy of my complete health care power of attorney.

_____ _____
(Date) *(Your Printed Name)*

_____
(Signature)