

# **DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

I, \_\_\_\_\_, am of

(Print or type your full name)

sound mind and I voluntarily make this designation.

## **APPOINTMENT OF PATIENT ADVOCATE**

I designate \_\_\_\_\_, my \_\_\_\_\_  
(Insert name of patient advocate) (Spouse, child, friend ...)

living at \_\_\_\_\_

(Address and telephone number of patient advocate)

as my patient advocate. If my first choice cannot serve, I designate

\_\_\_\_\_, my \_\_\_\_\_,  
(Name of successor patient advocate) (Spouse, child, friend ...)

living at \_\_\_\_\_

(Address and telephone number of successor patient advocate)

to serve as my patient advocate.

My patient advocate or successor patient advocate must sign an acceptance before he or she can act. I have discussed this appointment with the individuals I have designated as patient advocate and successor patient advocate.

## **GENERAL POWERS**

My patient advocate or successor patient advocate shall have power to make care, custody and medical treatment decisions for me if my attending physician and another physician or licensed psychologist determine I am unable to participate in medical treatment decisions.

In making decisions, my patient advocate shall try to follow my previously expressed wishes, whether I have stated them orally, in a living will, or in this designation.

My patient advocate has authority to consent to or refuse treatment on my behalf, to arrange medical and personal services for me, including admission to a hospital or nursing care facility, and to pay for such services with my funds.

My patient advocate shall have access to any of my medical records to which I have a right, immediately upon signing an Acceptance. This shall serve as a release under the Health Insurance Portability and Accountability Act.

Immediately upon signing an Acceptance, my patient advocate shall have access to my birth certificate and other legal documents needed to apply for Medicare, Medicaid, and other government programs.

## **POWER REGARDING LIFE-SUSTAINING TREATMENT**

(OPTIONAL)

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my death. My patient advocate can sign a do-not-resuscitate declaration for me. My patient advocate can refuse food and water administered to me through tubes.

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(Sign your name if you wish to give your patient advocate this authority)

## POWER REGARDING MENTAL HEALTH TREATMENT

(OPTIONAL)

I expressly authorize my patient advocate to make decisions concerning the following treatments if a physician and a mental health professional determine I cannot give informed consent for mental health care:

(check one or more consistent with your wishes)

☐ outpatient therapy

☐ my admission as a formal voluntary patient to a hospital to receive inpatient mental health services. I have the right to give three days notice of my intent to leave the hospital.

☐ my admission to a hospital to receive inpatient mental health services

☐ psychotropic medication

☐ electro-convulsive therapy (ECT)

☐ I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days notice of my intent to leave a hospital if I am a formal voluntary patient.

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(Sign your name if you wish to give your patient advocate this authority)

## POWER REGARDING ORGAN DONATION

(OPTIONAL)

I expressly authorize my patient advocate to make a gift of the following

(check any that reflect your wishes)

☐ any needed organs or body parts for the purposes of transplantation, therapy, medical research or education

☐ only the following listed organs or body parts for the purposes of transplantation, therapy, medical research or education:

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☐ my entire body for anatomical study

☐ (optional) I wish my gift to go to -

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(Insert name of doctor, hospital, school, organ bank or individual)

The gift is effective upon my death. Unlike other powers I give to my patient advocate, this power remains after my death.

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(Sign your name if you wish to give your patient advocate this authority)

## STATEMENT OF WISHES

My patient advocate has authority to make decisions in a wide variety of circumstances. In this document, I can express general wishes regarding conditions such as terminal illness, permanent unconsciousness, or other disability; specify particular types of treatment I do or not want in such circumstances; or I may state no wishes at all. If you have chosen to give your patient advocate power concerning mental health treatment, you can also include specific wishes about mental health treatment such as a preferred mental health professional, hospital or medication. (Choose A or B.)

A. My wishes are as follows (you may attach more sheets of paper):

**or**

B. I choose not to express any wishes in this document. This choice shall not be interpreted as limiting the power of my patient advocate to make any particular decision in any particular circumstance.

I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes or that I do not want my patient advocate to have authority to make decisions for me.

It is my intent no one involved in my care shall be liable for honoring my wishes as expressed in this designation or for following the directions of my patient advocate.

Photocopies of this document can be relied upon as though they were originals.

## **SIGNATURE**

I sign this document voluntarily, and I understand its purpose.

Dated: \_\_\_\_\_

Signed: \_\_\_\_\_

(Your signature)

\_\_\_\_\_  
(Your address and telephone number)

## STATEMENT REGARDING WITNESSES

I have chosen two adult witnesses who are not named in my will; who are not my spouse, parent, child, grandchild, brother or sister; who are not my physician or my patient advocate; who are not an employee of my life or health insurance company, an employee of a home for the aged where I reside, an employee of community mental health program providing me services or an employee at the health care facility where I am now.

## STATEMENT AND SIGNATURE OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____	_____
(Print name)	(Signature of witness)

_____
(Address)

_____	_____
(Print name)	(Signature of witness)

_____
(Address)

## ACCEPTANCE BY PATIENT ADVOCATE

**(1) This designation shall not become effective** unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift as described in section 5506, the authority remains exercisable after the patient's death.

**(2) A patient advocate shall not exercise powers** concerning the patient's care, custody and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

**(3) This designation cannot be used** to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

**(4) A patient advocate may make a decision** to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

**(5) A patient advocate shall not receive compensation** for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

**(6) A patient advocate shall act in accordance** with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.

**(7) A patient may revoke his or her designation** at any time or in any manner sufficient to communicate an intent to revoke.

**(8) A patient may waive his or her right to revoke** the patient advocate designation as to the power to make mental health treatment decisions, and if such waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

**(9) A patient advocate may revoke his or her acceptance** to the designation at any time and in any manner sufficient to communicate an intent to revoke.

**(10) A patient admitted to a health facility or agency has the rights** enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, Being Section 333.20201 of the Michigan Compiled Laws.

I, \_\_\_\_\_ understand the above

(Name of patient advocate)

conditions and I accept the designation as patient advocate or successor patient advocate for \_\_\_\_\_, who signed a

(Name of patient)

durable power of attorney for health care on the following date: \_\_\_\_\_

Dated: \_\_\_\_\_

Signed: \_\_\_\_\_

(Signature of patient advocate)

\_\_\_\_\_

(Signature of successor patient advocate)