DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, designate and appoint

Name of Appointee: _____

Address of Appointee: _____

Telephone Number of Appointee: _____

to be my agent for health care decisions and pursuant to the language stated below, on my behalf to:

1. Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, and to make decisions about organ donation, autopsy and disposition of the body;
2. make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care as the agent shall deem necessary for my physical, mental and emotional wellbeing; and
3. request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute any releases of other documents that may be required in order to obtain such information.

In exercising the grant of authority set forth above my agent for health care decisions shall: _____
_____
_____
(Here may be inserted any special instructions or statement of the principal's desires to be followed by the agent in exercising the authority granted).

LIMITATIONS OF AUTHORITY

1. The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for health care decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.
2. The agent shall be prohibited from authorizing consent for the following items: _____
   _____
   _____
3. This durable power of attorney for health care decisions shall be subject to the additional following limitations: _____
   _____
   _____

EFFECTIVE TIME

This power of attorney for health care decisions shall become effective (immediately and shall not be affected by my subsequent disability or incapacity or upon the occurrence of my disability or incapacity).

REVOCATION

Any durable power of attorney for health care decisions I have previously made is hereby revoked.

(This durable power of attorney for health care decisions shall be revoked by an instrument in writing executed, witnessed or acknowledged in the same manner as required herein or set out another manner of revocation, if desired.)

EXECUTION

Executed this _____, at _____, Kansas.

_____
Signature of Principal

This document must be: (1) Witnessed by two individuals of lawful age who are not the agent, not related to the principal by blood, marriage or adoption, not entitled to any portion of principal's estate and not financially responsible for principal's health care; OR (2) acknowledged by a notary public.

Witness: _____ Date: _____

Address: _____

Witness: _____ Date: _____

Address: _____

(OR)

STATE OF _____)

SS. COUNTY OF _____)

This instrument was acknowledged before me on this ____ day of _____, 20____by _____ _____.

(Seal, if any)

_____
Signature of notary public

My appointment expires:_____