Durable Power of Attorney for Health Care

I, _____ the principal, of _____, Montana, designate _____ as my attorney-in-fact and agent to act in my name and for my benefit as set forth herein. I grant to my agent full power to do everything necessary in exercising any of the powers herein granted as fully as I could do if personally present and fully competent, hereby ratifying all that my agent shall lawfully do or cause to be done by virtue of this power of attorney.

Should _____ die, become disabled, resign, or is determined by a court of competent jurisdiction to be incapacitated, I hereby appoint _____ as my successor attorney-in-fact to act in accordance with this instrument.

For this Health Care Power of Attorney ("HCPOA"), my "Agent" means either the Primary Agent or Successor Agent, but not both at the same time.

1. **Powers of Health Care over the Principal**

    1.1. **General Grant of Power.** My Agent shall have power to perform any act, power, duty, right, or obligation whatsoever that I now have or may hereafter acquire relating to matters involving my health and medical care. In exercising such powers, my Agent should attempt to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner. My Agent is further instructed that I if I am unable to give an informed consent to any medical care or treatment, my Agent shall give, withhold, withdraw, or modify such consent for me based upon any treatment choices that I have expressed while competent regarding medical procedures or interventions to prolong the dying process, to nourish and hydrate me, to provide for my comfort, or to alleviate pain. If my Agent cannot determine the treatment choice I would want made under the circumstances, then my Agent is authorized to make such choice for me based upon what my Agent believes to be in my best interest.

    1.2. **Specific Powers.** Without in any way limiting the generality of the power conferred upon my Agent under paragraph 1.1, my Agent shall have the specific powers set forth in this paragraph, 1.2.

(a) **Access to Medical Records.** To receive and review any information, verbal or written, regarding my physical or mental health, including medical and hospital records, to execute releases or other documents that may be required in order to obtain this information, and to disclose this information to such persons or entities as my Agent shall deem appropriate.

(b) **Employ and Discharge Health Care Personnel.** To employ medical personnel, to pay them reasonable compensation, and to discharge any such providers, including, but not limited to, physicians, psychiatrists, dentists, nurses, and therapists, as my Agent shall deem appropriate for my physical, mental, and emotional well-being.

(c) **Medical Care of Principal.** To give or withhold consent to any medical procedure, test or treatment, including surgery; to arrange for my hospitalization, convalescent care, nursing home, hospice or home care; to summon paramedics or other emergency personnel and seek emergency treatment for me, as my Agent shall deem appropriate; and under certain circumstances in which my Agent determines that certain medical procedures, tests, or treatments are no longer of any benefit to me or, where the benefits are outweighed by the burdens imposed, to revoke, withdraw, modify or change consent to such procedures, tests, or treatments, as well as hospitalization, convalescent care, nursing home, hospice, or home care, which I or my Agent may have previously consented to or to which consent may have been implied due to emergency conditions. My Agent's decision should be guided by taking into account (1) the provisions of this document, (2) any reliable evidence of preferences that I may have addressed on the subject, whether before or after the execution of this instrument, (3) what my Agent believes I would want done in the circumstances if I were able to express myself, and (4) any information given to my Agent by my attending physician regarding my medical diagnosis and prognosis, and the intrusiveness, pain, risks, and side effects associated with the procedure, test, or treatment.

(d) **Refusal or Withdrawal of Life-Sustaining Procedures.** I wish to live and enjoy life as long as possible. However, I do not wish to receive medical treatment, which will only postpone the moment of death from a medical condition that is incurable, terminal, or irreversible. Such medical conditions may include, but are not limited to, an irreversible coma or persistent vegetative state, a coma with a very slight and uncertain chance of recovery, irreversible brain damage or brain disease with or without a terminal illness, or terminal illness in conjunction with my inability to give informed consent to medical treatment. If a licensed physician who is familiar with my medical condition has diagnosed and noted in my medical records that my condition is incurable, terminal, or irreversible, and that I am unable to give informed consent to medical treatment, then my Agent is authorized to:

(i.) To sign on my behalf any documents necessary to exercise the powers conferred upon my Agent by this instrument, including waivers or releases of liability required by any health care provider

(ii.) To grant releases to hospital staff, physicians, nurses, other medical and hospital administrative personnel, and entities who act in reliance on the instructions of my Agent, from all liability for damages suffered or to be suffered by me resulting from actions which are in accord with the instructions of my Agent;

(iii.) To give or withhold consent to any medical care or treatment, to revoke or change any previous consent given by me or my Agent, or implied by law, for any medical care or treatment, and to arrange for my placement in or removal from any hospital, convalescent home, nursing home, hospice home, or other medical facility;

(iv.) To require that any life-sustaining procedures or treatment which will only postpone the moment of my death or prolong an irreversible coma not be instituted or, if previously instituted, be discontinued;

(v.) To require that procedures used to provide me with artificial nourishment and hydration not be instituted or, if previously instituted, be discontinued.

(vi.) To require the administration of drugs, other medications, and other treatments whose purposes are to keep me as comfortable and as free of pain as is reasonably possible, even though such drugs, medications, or treatments may have adverse side effects, may cause addiction, or may hasten the moment of, but not intentionally cause, my death.

1.3 **Incidental Powers.** My Agent, without the authority or approval of any court, is fully authorized to perform any acts and to execute and deliver any documents, instruments, and papers necessary, appropriate, incident, or convenient to the exercise of the powers granted by this instrument, including, without limitation, the following:

(a) **Resort to Courts.** To seek on my behalf and at my expense, from any court of competent jurisdiction:

(i.) A declaratory judgment interpreting this instrument and determining the validity of any act authorized by this instrument;

(ii.) A mandatory injunction requiring compliance by any person, association, or other legal entity with my Agent's instructions; and

(iii.) Actual and punitive damages against any person, association, or other legal entity who negligently or willfully fails or refuses to follow my Agent's instructions.

(b) **Employ Other Personnel.** To employ, compensate, and discharge such household workers, professional personnel, including lawyers, advisors, consultants, companions, servants, and other employees, as my Agent deems appropriate;

(c) **Execute Documents.** To execute and deliver agreements, receipts, releases, waivers, elections, vouchers, consents, and certificates related to the powers granted in this instrument;

(d) **Request Reimbursement.** My Agent will be entitled to reimbursement for all reasonable expenses incurred.

Reimbursement is to be paid by any Agent who exercises power over my financial affairs under any power of attorney or from any fiduciary under any trust instrument for my benefit or from any court-appointed conservator.

2. **Interpretation.** This instrument is to be construed and interpreted as a durable power of attorney for health care. The enumeration of specific powers is not intended to, nor does it, limit or restrict the general powers granted to my Agent.

3. **Revocability.** This instrument is revocable, provided I am competent to do so at the time. Insofar as any physician, hospital, hospital staff member, governmental agency, corporation, or other legal entities, or any other person is concerned, who shall rely upon this instrument, this instrument may be revoked only by a notice in writing executed by me or my Agent and delivered to such third party.

4. **Prior Documents.** I revoke any previous power of attorney for health care that I may have signed. This HCPOA shall supersede a Physician Order for Life Sustaining Treatment (POLST), advance directive, or similar document, whether created in the past or created in the future by someone other than my Agent, to the extent that document is inconsistent with my wishes expressed in this HCPOA or with my Agent's decisions on my behalf.

5. **Passage of Time.** This instrument shall not be revoked or otherwise become ineffective in any way by the mere passage of time, but rather shall remain in full force and effect until revoked by me or my Agent in writing, as provided in paragraph 3.

6. **Third-Party Reliance.** Third parties may rely upon the representations of my Agent as to all matters relating to any power granted to my Agent, and no third party who

may act in reliance upon the representations of my Agent or the authority granted to my Agent shall incur any liability to me or my estate as a result of permitting my Agent to exercise any power. My Agent is authorized to take legal action on behalf of me or my estate for any damages that may result from a third party's refusal to rely on the representations of my Agent or to recognize the authority herein granted to my Agent or failure to permit my Agent to exercise any power granted by this instrument.

7. **Disability of Principal.** This Durable Power of Attorney for Health Care shall not be affected by my incapacity or disability.

8. **Inducement.** For the purpose of inducing all persons, organizations, corporations, and entities including, but not limited to, any physician, hospital, nursing home, insurer, or other party to act in accordance with the powers granted in this instrument, I hereby represent, warrant, and agree, both for myself and on behalf of my heirs, distributes, legal representatives, successors, and assigns, that if this power of attorney is terminated for any reason whatsoever, I and my heirs, distributes, legal representatives, successors, and assigns will hold such party or parties harmless from any loss suffered or liability incurred by such party or parties in acting in accordance with this power of attorney prior to such third party's receipt of written notice of such termination.

9. **Exculpation.** Under no circumstances shall my Agent incur any liability to me, or to my heirs, distributes, legal representatives, successors, and assigns for acting or refraining from acting hereunder, except for my Agent's own willful misconduct or gross negligence.

10. **Nomination of Guardian.** If a petition is made on my behalf to a court, requesting appointment of a guardian of my estate or of my person, I nominate my acting Agent.

11. **Fiduciary Powers.** Notwithstanding any other provision of this Durable Power of Attorney for Health Care, my Agent shall have no rights or powers hereunder with respect to any act, power, duty, right, or obligation relating to any person, matter, transaction, or property owned by me or in my custody as a trustee, custodian, personal representative, or other fiduciary capacity.

12. **HIPPA Release Authority.** I intend for my Agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (a.k.a. HIPPA), 42 USC § 1320(d) and 45 CFR §§ 160-164. I authorize: any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered healthcare provider, any insurance company and the Medical Information Bureau Inc., or other health-care clearing house that has provided treatment or services to me, or that has paid for or is seeking payment from

me for such services, to give, disclose, and release to my Agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my Agent shall supersede any prior agreement that I may have made with my healthcare providers to restrict access to or disclosure of my individually identifiable health information. The authority given my Agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my healthcare provider.

13. **Living Will.** If I have previously executed a so-called "living will", to the extent my living will is applicable to my circumstances, the terms of my living will shall govern the withholding of medical treatment as therein provided; otherwise, my "living will" shall in no way be deemed to limit the powers of my Agent under this instrument.

14. **Governing Law.** This instrument is executed and delivered in the State of Montana, and the laws of the State of Montana shall govern all questions as to the validity and construction of this instrument.

15. **Counterparts and Photographic Copies.** This instrument may be executed in counterparts. Each executed counterpart is an original, and any photographic copy of this instrument shall have the force and effect of an original.

16. **Effective Date.** This power of attorney is effective immediately.

IN WITNESS WHEREOF, I have executed this Durable Power of Attorney for Health Care this _____ day of _____ , 20____.
Day Month Year

_____ _____
Name of Principal, Printed Principal Signature

State of Montana

County of

This instrument was acknowledged before me this _____ day of
Day
_____ , 20____, by_____.
Month Year Name of Notary Printed

(notarial seal)

_____
Notary Signature