DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

RELEASE OF MEDICAL INFORMATION UNDER 45 CFR 164.502(g)

The Agent/Attorney-in-fact named in this document is hereby designated as my "Personal Representative" as defined by 45 CFR 164.502(g), commonly known as the "Health Insurance Portability and Accounting Act of 1996 (HIPAA). This individual is to have the same access to my health care and treatment information as I would have if I were able to act for myself. My Agent/Attorney-in-fact and Personal Representative named herein is also authorized to take any and all legal steps necessary to ensure his or her access to this information and such action shall include, but not be limited to resorting to legal process to enforce my rights under the law and including the right to recover attorneys' fees, as authorized by the State of California in enforcing my rights.

California Medical Association

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(California Probate Code Sections 4700-4701)

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these important facts:

This document gives the person you designate as your agent (the attorney-in-fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent (1) authorizes anything that is illegal, (2) acts contrary to your known desires or (3) where your desires are not known, does anything that is clearly contrary to your best interests.

This power will exist for an indefinite period of time unless you limit its duration in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to (1) authorize an autopsy, (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

This power of attorney will not be valid for making health care decisions unless it is signed by two qualified adult witnesses who are present when you sign or acknowledge your signature.

ADVANCE HEALTH CARE DIRECTIVE
(California Probate Code § 4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or discharge health care providers and institutions.

(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

(e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

You are free to use a different form.

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I, JOHN C. SAMPLE, designate the following individual as my agent to make health care decisions for me:

Name: JOHN C SAMPLE JR

APPOINTMENT OF ALTERNATE AGENT (OPTIONAL)

(You may appoint alternate agents to make health care decisions for you in case the person you appointed in above is unable or unwilling to do so.)

JOAN C SAMPLE

(1.2) GRANT OF AUTHORITY TO MY AGENT AND AUTHORIZATION UNDER HIPAA AND CALIFORNIA LAW FOR THE INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive, to the extent I could do so individually, any information, verbal or written, regarding my physical or mental health, including, but not limited to, 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 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160-164, and the California Confidentiality of Medical Information Act ("CMIA"), California Civil Code § 56. I hereby authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse 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. This authority given my agent shall supersede any other agreement which I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. This authority given my agent shall be effective immediately, has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider;

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information;

(c) Consent to the disclosure of this information;

(d) Appoint a "Patient Advocate" for me who shall have the same right to ask questions and obtain information as my agent under this directive; and

(e) Transfer my care to another health care provider if my health care provider refuses to honor my Advance Health Care Directive. I also direct and empower my agent under this Directive to pursue any appropriate actions against my health care provider(s) in the event my Advance Health Care Directive is not honored.

AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(1.3) SIGNING DOCUMENTS, WAIVERS, AND RELEASES. When necessary to implement the health care decisions that my agent is authorized by this Directive to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice" and;

(b) Any necessary waiver or release from liability required by a hospital or physician.

(1.4) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

If I mark this box ☐, my agent's authority to make health care decisions for me takes effect immediately.

(1.5) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.6) AGENT'S POST DEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

(1.7) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

( ) (a) Choice Not To Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

( ) (b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

_____

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

PART 3

DONATION OF ORGANS AT DEATH
(OPTIONAL)

(3.1) Upon my death (mark applicable box):

( ) (a) I give any needed organs, tissues, or parts, OR

( ) (b) I give the following organs, tissues, or parts only.

(c) My gift is for the following purposes (strike any of the following you do not want):

(1) Transplant

(2) Therapy

(3) Research

(4) Education

PART 4

PRIMARY PHYSICIAN
(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

_____
(Name of physician)

_____
(Address) (City) (State) (ZIP Code)

Phone: _____

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(Name of physician)

_____
(Address) (City) (State) (ZIP Code)

Phone: _____

PART 5

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here:

Dated: December 1, 2022

_____

(JOHN C. SAMPLE)

Address: 123 ELM ST, OAK, CA 12345-6789.

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration: I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

DATED: December 1, 2022 **WITNESS:**

Signature: /s/_____
22336 HARPER AVENUE
ST. CLAIR SHORES, MI 48081

DATED: December 1, 2022 **WITNESS:**

Signature: /s/_____
22336 HARPER AVENUE
ST. CLAIR SHORES, MI 48081

State of Michigan)
) ss.
County of Macomb)

Acknowledged by JOHN C. SAMPLE, before me on December 1, 2022.

Signature: _____
Notary, Public, State of Michigan, County of Macomb