DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(Medical Power of Attorney)

I, _____ , born _____, designate

_____

_____

(Type or Print) Name of Agent, Street Address, City, State, Zip Code and Phone Number.

as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of the State of Iowa, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including 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 my desires and any limitations included in this document.

I hereby revoke all prior Durable Powers Of Attorney for Health Care Decisions.

OPTIONAL: If the person designated as agent above is unable to serve, I designate the following person to serve instead:

_____

_____

(Type or Print) Name of Agent, Street Address, City, State, Zip Code and Phone Number.

OPTIONAL: ADDITIONAL PROVISIONS - Insert here specific instructions or statement of desires (if any):

YES __ NO __ In the event that medical professionals determine that I may be an organ donor, I agree to the use of life-sustaining procedures, including a ventilator, for the sole purpose and time period required to complete the organ donation. Nothing in this paragraph shall be construed to expand or detract from the laws related to anatomical gifts as outlined in the Iowa Code, Chapter 142C. The purpose of this paragraph is to practically and medically make organ donation possible.

Signed this this ____ day of _____, _____.

_____ _____

Type or Print Your Name Your Signature (Declarant/Principal)

_____

Address, Street, City State and Zip

This Power of Attorney must be witnessed by two persons or notarized.

Durable Power of Attorney for Health Care Decisions Form for _____

STATE OF _____, COUNTY OF _____

This record was acknowledged before me this ____ day of _____, _____, by _____.

_____
Signature of Notary Public

By signing this form I declare that I signed this form in the presence of the other witness and the Principal and I witnessed the signing by the Principal or other person acting on behalf of and at the Principal's direction.

WITNESS FORM

_____	_____
Signature of First Witness	Signature of Second Witness
_____	_____
Type or Print Name of Witness	Type or Print Name of Witness
_____	_____
_____	_____
Street Address, City, State, Zip Code	Street Address, City, State, Zip Code

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO NOMINATED HEALTH CARE ATTORNEY-IN-FACT

Pursuant to the terms of a Durable Power of Attorney, Health Care Decisions, (or Combined Living Will and Medical Power of Attorney) (HCPOA) dated _____, in which the undersigned is the grantor, the power becomes effective in the event of my disability or incapacity.

AUTHORIZATION TO RELEASE INFORMATION:

I 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 the person or persons designated in this document to act as my agent such of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition

(including all specially protected health information relating to each of the following conditions specifically authorized by me to be disclosed by marking the box with an "X" or a check mark:
___ sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV);
___ behavioral and mental health; and
___ alcohol, drug and other substance abuse)

_____ _____
Signature of Principal Date

relating to my ability to make health care decisions. The purpose of this request is to assist in determining whether the person designated to act as my agent should act as my agent. This authorization expires when I die or when revoked by me by a written revocation signed by me and delivered to the entity from which information is being requested prior to the time information is being requested.

I understand I can revoke this authorization by delivering a written statement of revocation to any entity I have authorized to give, disclose and release information. The revocation is effective only as to those entities to whom the written statement revocation is given and only after the time of delivery. I also understand that I have the right to inspect the disclosed information at any time. My treatment, payment, enrollment or eligibility for benefits with an entity that I have authorized to release information is not conditioned on my signing this authorization. I know that once the information I have authorized to be released is released it is subject to re-disclosure by the recipient and is no longer protected by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto, as amended from time to time.

THE AUTHORITY TO ACT AS PERSONAL REPRESENTATIVE

In addition to the other powers granted by the HCPOA, I grant to my agent the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and its regulations (HIPAA) during any time that my agent (hereinafter referred to in subsequent clauses of this paragraph as my "HIPAA personal representative") is exercising authority under this document.

Pursuant to HIPAA, I specifically authorize my HIPAA personal representative to request, receive and review any information regarding my physical or mental health, including without limitation all HIPAA-protected health information, medical and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required in order to obtain this information and to consent to the disclosure of this information. I further authorize my HIPAA personal representative to execute on my behalf any documents necessary or desirable to implement the health care decisions that my HIPAA personal representative is authorized to make under the HCPOA.

Dated this ____ day of _____, _____.

_____

,Declarant

GENERAL INFORMATION ON DURABLE POWER OF ATTORNEY FOR HEALTH CARE

A durable power of attorney for health care is subject to the provisions of Chapter 144B of the Code of Iowa and reference should be made to that chapter. The following is a summary of some of the provisions of Chapter 144B of the Code of Iowa.

1. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. "Health care" does not include the provision of nutrition or hydration except when they are required to be provided parenterally or through intubation.

2. The following individuals shall not be witnesses for a durable power of attorney for health care:
    a. A health care provider attending the principal on the date of execution.
    b. An employee of a health care provider attending the principal on the date of execution.
    c. The individual designated in the durable power of attorney for health care as the attorney in fact.
    d. An individual who is less than eighteen years of age.

3. One of the witnesses shall be an individual who is not a relative of the principal by blood, marriage, or adoption within the third degree of consanguinity.

4. The following individuals shall not be designated as the attorney in fact to make health care decisions under a durable power of attorney for health care:
    a. A health care provider attending the principal on the date of execution.
    b. An employee of a health care provider attending the principal on the date of execution unless the individual to be designated is related to the principal by blood, marriage, or adoption within the third degree of consanguinity.

5. Revocation.
    a. A durable power of attorney for health care may be revoked at any time and in any manner by which the principal is able to communicate the intent to revoke, without regard to mental or physical condition.
    b. Revocation may be made by notifying the attorney in fact orally or in writing.
    c. Revocation can also be made by notifying a health care provider orally or in writing while that provider is engaged in providing health care to the principal.
    d. A revocation is only effective as to a health care provider upon its communication to the provider by the principal or by another to whom the principal has communicated revocation.
    e. The health care provider is required to document the revocation in the treatment records of the principal.
    f. The principal is presumed to have the capacity to revoke a durable power of attorney for health care.
    g. Unless it provides otherwise, a valid durable power of attorney for health care revokes any prior durable power of attorney for health care.

6. Prohibited Practices.
    a. A health care provider, health care service plan, insurer, self-insured employee welfare benefit plan, or nonprofit hospital plan shall not condition admission to a facility, or the providing of treatment, or insurance, on the requirement that an individual execute a durable power of attorney for health care.
    b. A policy of life insurance shall not be legally impaired or invalidated in any manner by the withholding or withdrawing of health care pursuant to the direction of an attorney in fact appointed pursuant to this Chapter.

7. It is the responsibility of the principal to notify the health care provider (doctor) of the terms of the Durable Power of Attorney for Health Care.

SUGGESTIONS AFTER FORM IS PROPERLY SIGNED, WITNESSED OR NOTARIZED

1. Place original in a safe place known and accessible to family members or close friends.

2. Provide a true copy to your doctor.

3. Provide a copy(s) to family member(s).

4. Provide a copy to designated attorney in fact (agent) and to alternate designated attorney (s) in fact (if any).