

IDAHO DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. **Designation of Health Care Agent** - I, _____, do hereby designate and appoint _____ (name, address and telephone number), as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical condition.

2. **Creation of Durable Power of Attorney for Health Care** - By this document I intend to create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity.

3. **General Statement of Authority Granted** - Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document, or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

4. **Statement of Desires, Special Provisions, and Limitations** - (You can, but are not required to, state your desires below.) In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated in the living will. Additional statement of desires, special provisions, and limitations:

- {a}
- {b}
- {c}

5. **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 any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records;
- {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} Consent to the donation of any of my organs for medical purposes. (This statement should be crossed out if organ donation is not desired)

6. **Signing Documents, Waivers, and Releases** - Where necessary to implement the health care decisions that my agent is authorized by this document 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."
- {b} Any necessary waiver or release from liability required by a hospital or physician.

7. **Designation of Alternate Agents** - If the person designated as my agent in Paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

First Alternative Agent
Name:
Address:
Telephone:

Second Alternative Agent
Name:
Address:
Telephone:

8. **Prior Designations Revoked** - I revoke any prior durable power of attorney for health care.

9. **Law That Governs** - This durable power of attorney for health care is made by me as an Idaho resident. This instrument is in the document form prescribed by Idaho Code Section 39-4505 and shall be governed by the Idaho Natural Death Act.

10. **Signature** - I sign my name to this Statutory Form Durable Power of Attorney for Health Care on the _____ day of _____ in the year _____, at _____, _____.

(signature)

(You must choose to have this Durable Power of Attorney for Health Care notarized **or** witnessed by two people who know you well, but aren't related to you and aren't potential heirs or your health care providers)

(Witness Option)

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of Idaho that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

I further declare under penalty of perjury under the laws of the State of Idaho that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

WITNESS A

Signature/Date:
Print Name:
Address:

WITNESS B

Signature/Date:
Print Name:
Address:

(Notary Option)

STATE OF IDAHO }
 : ss
County of _____ }

On this _____ day of _____, in the year _____, before me personally appeared _____, to me known (or proved to me on basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, as the principal and acknowledged that he/she executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

Notary Public for the State of Idaho
My Commission Expires: