memorial regional health

Medical Durable Power of Attorney For Healthcare Decisions (MDPOA)

Name of Declarant _____ DOB _____

Address _____ Phone # _____

1. Appointment of Agent and Alternates
I, the Declarant, hereby appoint:

_____
Name of Agent - Relationship

_____
Agent's Best Contact Telephone Number

_____
Agent's Home Address

as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, refuse, or stop any healthcare, treatment, service or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed below.

_____
Name of Alternate Agent #1 - Relationship

_____
Agent's Best Contact Telephone Number

_____
Agent's Home Address

_____
Name of Alternate Agent #2 - Relationship

_____
Agent's Best Contact Telephone Number

_____
Agent's Home Address

2. Instructions to Agent
My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines to be in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

Optional: State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:

_____

_____

_____

_____

My signature below indicates that I understand the purpose and effect of this document. I do hereby revoke and cancel any and all prior Medical Powers of Attorney that I may have previously done and executed:

_____
Signature of Declarant Date

3. Signature of Witnesses and Notary (Optional)
The signature of two witnesses and a notary are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We are at least eighteen (18) years old.

_____
Signature of Witness

_____
Printed Name

_____
Address

_____
Signature of Witness

_____
Printed Name

_____
Address

Notary (Optional)
State of _____
County of _____
SUBSCRIBED and sworn to before me by _____, the Declarant, as the voluntary act and deed of the Declarant this_____ day of _____, 20_____
Notary Public_____
My commission expires: _____