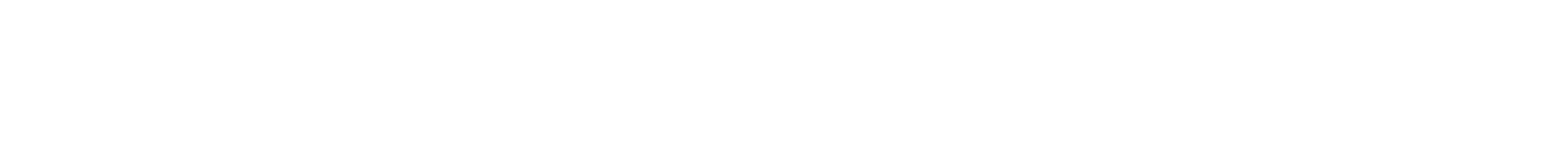
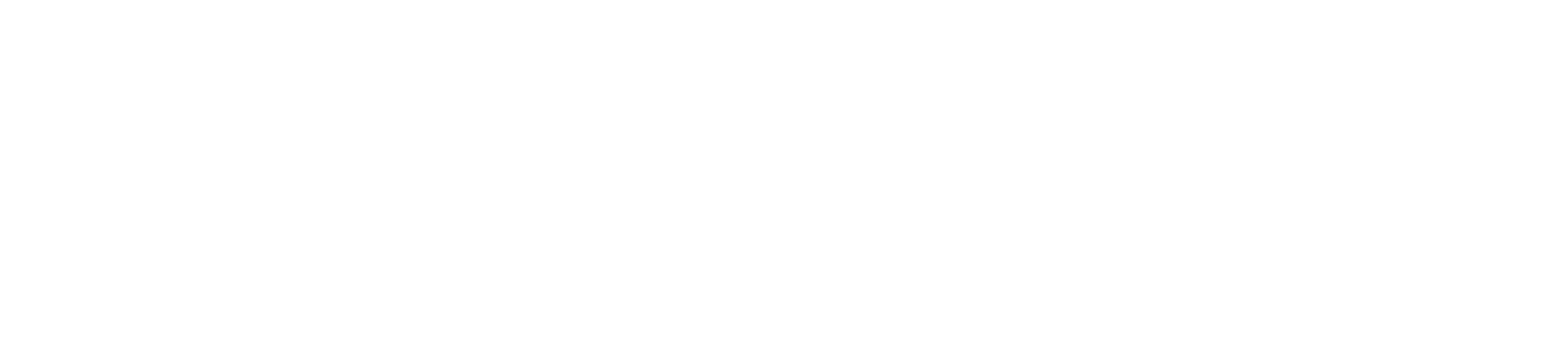
South Dakota: Health Care Proxy





NOTE: This form is being provided to you as a public service. The attached forms are provided “as is” and are not the substitute for the advice of an attorney.

By providing these forms and information, Everplans is not providing legal advice to you. Consult an attorney if you need legal advice of any nature.

Read more and get more forms at Everplans’ [Advance Directive page.](https://www.everplans.com/tools-and-resources/state-by-state-advance-directive-forms)

# Durable Power of Attorney *for Health Care*

Fill out this document carefully. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This document will be in effect unless or until you revoke it. You may change or revoke this document at any time by telling your doctor and other healthcare providers. You should give copies of this document to your family, your doctor and your health care facility. This form is optional. If you choose to use this form, the form has a signature line for you and a notary.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I, |  | , |  | appoint |
|  | *(Principal/Patient)* |  | *(Birthday)* | *(Decision Maker/Agent)* |

as my Attorney-In-Fact for the purpose of making healthcare decisions on my behalf. In the event the person named above is unable or unwilling to act as my Attorney-In-Fact, I appoint

*(Optional)* as my Attorney-In-Fact. In the event both of the previously named persons are either unable or unwilling to act as my Attorney In Fact, I appoint

(Optional) as my Attorney-In-Fact. This Power of Attorney shall become effective upon my disability as authorized by SD Codified Law §§ 59-7-2.1-2.8.

**I grant my Attorney-In-Fact the power to:**

*(Initial)* Make any and all health care decisions on my behalf, including each of the powers identified in items 1-7 below:

## OR

**I only grant my Attorney-In-Fact the power to (initial each power granted):**

1. Consent to healthcare on my behalf.
2. Withdraw consent for healthcare.
3. Reject care or treatment recommended by a healthcare provider in accordance with my previously stated wishes.
4. Authorize a healthcare provider to withhold care or treatment when such care or treatment would prolong my suffering.
5. Authorize artificial nutrition to be withheld or withdrawn.
6. Authorize artificial hydration to be withheld or withdrawn. 7) Other /Additional Instructions (specify):

Dated this, the day of , 20 .

*(Principal/Patient)* State of South Dakota )

) ss

County of Pennington )

On this day ,20 , , known to me or satisfactorily

proven to be the person named above, personally appeared before me, a Notary Public with the State of South Dakota, and acknowledged that he or she executed the same for the purposes stated herein.

**Notary Public**

My commission expires

Produced by

Learning & Development Department

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Fairmont Boulevard, Rapid City, SD 57701

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