HEALTH CARE POWER OF ATTORNEY
Instructions and Information

GENERAL INSTRUCTIONS: Use this form if you want to select a person, called an "agent", to make future health care decisions for you so that if you become too ill or cannot make those decisions for yourself the person you choose and trust can make medical decisions for you. Be sure you understand the importance of this document. It is a good idea to talk to your doctor and loved ones if you have questions about the type of health care you do or do not want.

AUTOPSY CHOICE: If there is no legal reason to require an autopsy, you can decide if you want one done when you die, or whether you want your agent to choose for you. There is usually a charge for voluntary autopsies. You can help your family and loved ones by making your preferences on this topic clear. For additional information on autopsies please review Arizona Revised Statutes §§ 11-591 and 11-597.

ORGAN DONATION CHOICE (OPTIONAL): You can determine if you want to donate organs or tissues, and if you do, what organs or tissues you want to donate, for what purposes, and to what organizations. You also have the option of whole-body donation for research purposes. You can also choose to have your agent decide. For additional information on Organ Donation, please review Arizona Revised Statutes §§ Title 36, Chapter 7, Article 3 for the laws that pertain to it.

FUNERAL AND BURIAL CHOICE (OPTIONAL): You can determine, your funeral and burial choices in this form. You can select if, upon your death, you would like to be buried and where, or if you would like to be cremated and where your ashes will go, or you can select your agent to make that choice.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it.

PLEASE NOTE: At least one adult witness, not to include the proxy if there is one, OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:
(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

OFFICE OF THE ARIZONA ATTORNEY GENERAL
MARK BRNOVICH

Health Care Power of Attorney

My Information (I am the "Principal"):

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

Selection of my health care power of attorney and alternate:

I choose the following person to act as my agent to make health care decisions for me:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

I choose the following person to act as an alternate to make health care decisions for me if my first agent is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

I AUTHORIZE my agent to make health care decisions for me when I cannot make or communicate my own health care decisions. I want my agent to make all such decisions for me except any decisions that I have expressly stated in this form that I do not authorize him/her to make. My agent should explain to me any choices he or she made if I am able to understand. I further authorize my agent to have access to my "personal protected health care information and medical records". This appointment is effective unless it is revoked by me or by a court order.

Health care decisions that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself: (Explain or write in "None")

_____

_____

_____

My specific wishes regarding autopsy (additional information on page 1):

*Please note that if not required by law a voluntary autopsy may cost money. Initial your choice.

_____**:** Upon my death I DO NOT consent to a voluntary autopsy.

_____**:** Upon my death I DO consent to a voluntary autopsy.

_____**:** My agent may give or refuse consent for an autopsy.

My specific wishes regarding organ donation (additional information on page 1):

If you do not initial this section your agent may make these decisions for you. Initial your choice.

_____**:** I DO NOT WANT to make an organ or tissue donation, and I DO NOT want this donation authorized on my behalf by my agent or my family.

_____**:** I have already signed a written agreement or donor card regarding donation with the following individual or institution: _____

_____**:** I DO WANT to make an organ or tissue donation when I die. Here are my directions:

1. **What organs/tissues I choose to donate (initial below):**
   a. _____**:** Whole body
   b. _____**:** Any needed parts or organs
   c. _____**:** These parts or organs only:
      i. _____

2. **I am donating organs/tissue for (initial below):**
   a. _____**:** Any legally authorized purpose
   b. _____**:** Transplant or therapeutic purposes only
   c. _____**:** Research only
   d. _____**:** Other: _____

3. **The organization or person I want my organs/tissue to go to are (initial below):**
   a. _____**:** _____
   b. _____**:** Any that my agent chooses

My specific wishes regarding funeral and burial disposition (additional information on page 1):

_____**:** Upon my death, I direct my body to be buried. (Instead of cremated)

_____**:** Upon my death, I direct my body to be buried in: _____

_____**:** Upon my death, I direct my body to be cremated.

_____**:** Upon my death, I direct my body to be cremated with my ashes to be _____

_____

_____**:** My agent will make all funeral and burial decisions.

Do you have a living will?

If you have a Living Will, **you must attach** the Living Will to this form. A blank Living Will is available on the Attorney General's website www.azag.gov. Initial below.

_____**:** I have SIGNED AND ATTACHED a completed Living Will to this Health Care Power of Attorney.

_____**:** I have NOT SIGNED a Living Will.

Do you have a POLST (Portable Medical Order)?

A **POLST** form is for when you become seriously ill or frail and toward the end of life. A blank POLST is available on the Attorney General's website www.azag.gov. Initial below.

_____**:** I have SIGNED AND ATTACHED a completed POLST to this Health Care Power of Attorney.

_____**:** I have NOT SIGNED a POLST.

Do you have a Prehospital Medical Care Directive – a type of Do Not Resuscitate form (DNR)?

A blank Prehospital Medical Care Directive or DNR is available on the Attorney General's website www.azag.gov. Initial below.

_____**:** I and my doctor or health care provider HAVE SIGNED a Prehospital Medical Care Directive or DNR on Paper with ORANGE background in the event that Emergency Medical Technicians or hospital emergency personnel are called and my heart or breathing has stopped.

_____**:** I have NOT SIGNED a Prehospital Medical Care Directive or DNR.

PHYSICIAN AFFIDAVIT (OPTIONAL)

You may wish to ask questions of your physician regarding a particular treatment or about the options in the form. If you do speak with your physician it is a good idea to ask your physician to complete this affidavit and keep a copy for his/her file.

I, Dr. _____ have reviewed this document and have discussed with _____ any questions regarding the probable medical consequences of the treatment choices provided above. This discussion with the principal occurred on this day _____.

I have agreed to comply with the provisions of this directive.

_____
Signature of Physician

HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT

_____ **(Initial)** I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of 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 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

Revocability of this Health Care Power of Attorney: I retain the right to revoke all or any portion of this form or to disqualify any agent designated by me in this document.

MY SIGNATURE VERIFICATION FOR THE HEALTH CARE POWER OF ATTORNEY

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document, your witness/notary may sign and initial for you. If applicable have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Health Care Power of Attorney expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS (See Page 1 for who CANNOT be a witness)

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form. I affirm that I meet the requirements to be a witness as indicated on page one of the health care power of attorney form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY (See Page 1 for who CANNOT be a Notary)

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

NOTORIAL JURAT: Pertains to all five pages of this Health Care Power of Attorney Dated _____, 20_____.

STATE OF ARIZONA) ss

COUNTY OF _____)

_____

Principal's Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____

My Commission Expires: _____