

# **HEALTH CARE POWER OF ATTORNEY**

**(MUST BE SIGNED AND WITNESSED IN THE PRESENCE OF A NOTARY)**

## HEALTH CARE POWER OF ATTORNEY

**NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS WELL AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.**

**EXPLANATION:** *You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.*

*This document gives the person you designate as your health care agent **broad powers** to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.*

*This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.*

*This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.*

*If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. **Do not sign this form until** two witnesses and a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State:  
<http://www.nclifelinks.org/ahcdr/>*

### 1. Designation of Health Care Agent.

I, \_\_\_\_\_, being of sound mind, hereby appoint the following person(s) to serve as my health care agent(s), to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent shall serve alone, in the order named.

A. Name: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
\_\_\_\_\_ Cellular Telephone: \_\_\_\_\_

B. Name: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
\_\_\_\_\_ Cellular Telephone: \_\_\_\_\_

C. Name: \_\_\_\_\_ Home Telephone: \_\_\_\_\_  
Home Address: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
\_\_\_\_\_ Cellular Telephone: \_\_\_\_\_

Any successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or unwilling or unable to serve in that capacity.

## **2. Effectiveness of Appointment.**

My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if one of the physicians(s) listed below determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, the authority will continue after my death to the extent necessary to exercise that authority.

- 1.
- 2.

If I have not designated a physician, or no physician(s) named above is reasonably available, the determination that I lack capacity to make or communicate decisions relating to my health care shall be made by my attending physician.

## **3. Revocation.**

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

## **4. General Statement of Authority Granted.**

Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

- A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.
- B. Employing or discharging my health care providers.
- C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility.
- D. Consenting to and authorizing my admission to and retention in a facility for care or treatment of mental illness.
- E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."
- F. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power of consent to measures for relief of pain.
- G. Authorizing the withholding or withdrawal of life-prolonging measures.



 <hr/> (Initial)	B. <u>Limitations Concerning Health Care Decisions.</u> In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions: [Here you may include any specific provisions you deem appropriate such as: your own definition of when life-prolonging measures should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or are unacceptable to you for any other reason.]
	<b>NOTE: DO NOT initial unless you insert a limitation.</b>
 <hr/> (Initial)	C. <u>Limitations Concerning Mental Health Care Decisions.</u> In exercising the authority to make mental health decisions on my behalf, the authority of my health care agent is subject to the following special provisions: [Here you may include any specific provisions you deem appropriate such as : limiting the grant of authority to make only mental health treatment decisions, your own instructions regarding the administration or withholding of psychotropic medications and electroconvulsive treatment (ECT), instructions regarding your admissions to and retention in a health care facility for mental health treatment, or instructions to refuse any specific types of treatment that are unacceptable to you.]
	<b>NOTE: DO NOT initial unless you insert a limitation.</b>
 <hr/> (Initial)	D. <u>Advance Instruction for Mental Health Treatment.</u> [Notice: This health care power of attorney may incorporate or be combined with an advance instruction for mental health treatment, executed in accordance with Part 2 of Article 3 of Chapter 122C of the General Statutes, which you may use to state your instruction for mental health treatment decisions. Because your health care agent's decisions must be consistent with any statements you have expressed in an advance instruction, you should indicate here whether you have executed an advance instruction for mental health treatment]:
	<b>NOTE: DO NOT initial unless you insert an indication.</b>
 <hr/> (Initial)	E. <u>Autopsy and Disposition of Remains.</u> In exercising the authority to make Decisions regarding autopsy and disposition of remains on my behalf, the Authority of my health care agent is subject to the following special provisions and Limitations. (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding burial or cremation):
	<b>NOTE: DO NOT initial unless you insert a limitation.</b>

**6. Organ Donation.**

To the extent I have not already made valid and enforceable arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

<hr/> <i>(Initial)</i>	donate any needed organs or parts; or
<hr/> <i>(Initial)</i>	donate only the following organs or parts: _____
	<b>NOTE: DO NOT INITIAL BOTH BLOCKS ABOVE</b>
<hr/> <i>(Initial)</i>	donate my body for anatomical study if needed.
<hr/> <i>(Initial)</i>	In exercising the authority to make donations, my health care agent is subject to the following special provisions and limitations: (Here you may include any specific limitations you deem appropriate such as: limiting the grant of authority and the scope of authority, or instructions regarding gifts of the body or body parts): _____ _____ _____
	<b>NOTE: DO NOT initial unless you insert a limitation.</b>

**NOTE: NO AUTHORITY FOR ORGAN DONATION IS GRANTED IN THIS INSTRUMENT WITHOUT YOU INITIALS.**

**7. Guardianship Provision.**

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(2)(5).

**8. Reliance of Third Parties on Health Care Agent.**

- A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions in reliance on that authority or those representations.
- B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

**9. Miscellaneous Provisions.**

- A. **Revocation of Prior Powers of Attorney.** I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this

power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.

- B. Jurisdiction, Severability and Durability. This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.
- C. Health Care Agent Not Liable. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.
- D. No Civil or Criminal Liability. No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.
- E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant powers to my health care agent.

This the \_\_\_\_ day of \_\_\_\_\_, 20\_\_

\_\_\_\_\_(SEAL)

I hereby state that the principal, \_\_\_\_\_, being of sound mind, signed by the foregoing Health Care Power of Attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

NORTH CAROLINA  
\_\_\_\_\_ COUNTY

Sworn to (or affirmed) and subscribed before me this day by:

\_\_\_\_\_  
(signer)

\_\_\_\_\_  
(witness)

\_\_\_\_\_  
(witness)

This the \_\_, day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_, Notary Public

My commission expires: \_\_\_\_\_