

HEALTH CARE POWER OF ATTORNEY

I, _____, as principal, designate _____, as my agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital, psychiatric and related health care. This power of attorney is effective when I am unable to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when it is unclear whether I am dead or alive, have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint _____ as my agent.

I have _____ I have not _____ completed and attached a living will to provide specific direction to my agent. My agent is directed to follow these choices I have initialed in the living will.

I have _____ I have not _____ completed a pre-hospital medical directive pursuant to Section 36-3251 Arizona Revised Statutes.

This health care directive is made under Section 36-3221 Arizona Revised Statutes, and continues in effect for all who may rely on it except those whom I have given notice of its revocation.

Selection of my health care representative and alternate: (Also called an "agent" or "surrogate")

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

Name: _____ Home Telephone: _____
Street Address: _____ Work Telephone: _____
City, State, Zip: _____ Cell Telephone: _____

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

Name: _____ Home Telephone: _____
Street Address: _____ Work Telephone: _____
City, State, Zip: _____ Cell Telephone: _____

Signature or Mark of Person Completing Document

DATE

I affirm that: (1) I was present when this health care power of attorney was dated and signed or marked or (2) that the person making this power of attorney directly indicated to me that the power of attorney expressed that person's wishes and that the person intended to adopt this power of attorney at that time. The maker of this document appeared to be of sound mind and free from duress.

(If only one witness is signing) I certify that: I have not been designated to make medical decisions for the person who signs this health care power of attorney, I am not directly involved with providing health care to that person, I am not related to that person by blood, marriage, or adoption, and I am not entitled to any part of that person's estate.

WITNESS

DATE

WITNESS

DATE