Indiana Medical Power of Attorney Form

INDIANA MEDICAL POWER OF ATTORNEY FORM

Attorney-in-fact appointment

I grant my attorney-in-fact the following powers in matters affecting my health care:

1. to employ or contract with servants, companions, or health care providers involved in my health care;

2. to consent to or refuse any health care, treatment, service, or procedure to maintain, diagnose, treat, or not to treat my physical or mental conditions;

3. to consent to my admission or release me from a hospital or health care facility;

4. to have access to my records, including medical records, concerning my condition;

5. to make anatomical gifts on my behalf;

6. to request an autopsy; and

7. to make plans for the disposition of my body.

Alternate attorney-in-fact appointment

Executed on: _____ dd / mm / yyyy

Signed:
Printed name: _____

Witness signature (an adult other than the health care representative):
Printed name of witness: _____ **Date:** _____ dd / mm / yyyy

APPOINTMENT OF MY ATTORNEY-IN-FACT AS MY HEALTHCARE REPRESENTATIVE; DECISIONS REGARDING WITHDRAWING OR WITHHOLDING HEALTHCARE

In addition to the powers granted above, I appoint my attorney-in-fact as my Healthcare Representative and authorize my attorney-in-fact and Healthcare Representative to make decisions in my best interest concerning the consent, withdrawal, or withholding of healthcare. I declare competence and full understanding of the delegation of authority for this significant responsibility. I understand healthcare includes any medical care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental well-being.

Healthcare also includes the provision of nutrition and hydration through intravenous, gastrostomy, or nasogastric tubes. If, at any time, based on my previously expressed preferences and the diagnosis and prognosis, my Healthcare Representative is satisfied that certain healthcare is not or would not be beneficial or that such healthcare is or would be excessively burdensome, then my Healthcare Representative may express my will that such healthcare be withheld or withdrawn and may consent on my behalf that any or all healthcare be discontinued or not instituted, even if death may result.

My Healthcare Representative must try to discuss this decision with me. However, if I am unable to communicate, my Healthcare Representative may make such a decision for me after consulting with my physician or physicians and other relevant health caregivers. To the extent appropriate, my Healthcare Representative may also discuss this decision with my family and others when they are available.

Executed on: _____ dd / mm / yyyy

Signed:
Printed name: _____

Witness signature (an adult other than the Healthcare Representative):
Printed name of witness: _____ **Date:** _____ dd / mm / yyyy

Subscribed and acknowledged before me by:

Notary public: _____ **My commission expires:** _____