MEDICAL POWER OF ATTORNEY
DURABLE POWER OF ATTORNEY (ADVANCE DIRECTIVES)
FOR HEALTH CARE DECISIONS

"I hereby designate ____ as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of this state, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or withdraw consent to the provision of any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document."

My agent has the right to examine my medical records and to consent to disclosure of such records.*

NOTE: Write specific instructions or statement of desires regarding health care (optional).

DESIGNATED ATTORNEY IN FACT	ALTERNATE ATTORNEY IN FACT (OPTIONAL) If the person designated above is unable to serve, I designate the following to serve as my attorney in fact.
_______________________ Name	_______________________ Name
_______________________ Street Address	_______________________ Street address
_______________________ City State Zip	_______________________ City State Zip
_______________________ Telephone	_______________________ Telephone

Signed this _____ Day of _________________________________, 20 _____

____

Signature of Person Granting Power of Attorney

____

Type or Print Name

____

Street Address Date of Birth

____

City State Zip

THIS MEDICAL POWER OF ATTORNEY MUST BE WITNESSED BY TWO PERSONS OR NOTARIZED.

NOTARY	WITNESS
On this ______ day of ________________, AD 20 ______ before me, the undersigned, a Notary Public in and for the State of Iowa, personally appeared _________________________ to me known to be the person named in and who executed the foregoing instrument, and acknowledge that he/she executed the same as his/her voluntary act and deed.	The witnesses whose signatures appear below have signed the same in the presence of each other and did witness the signature of the person executing this document (or the executing of this document by the person acting on his/her behalf and at his/her direction).
	_______________________ Signature of First Witness
	_______________________ Type or Print Name of Witness
	_______________________ Street Address
	_______________________ City State Zip
	_______________________ Signature of Second Witness
	_______________________ Type or Print Name of Witness
____, Notary Public	_______________________ Street Address
*All areas appearing in quotation taken from Iowa House File 501, Section 144B.1	_______________________ City State Zip

INSTRUCTIONS

1. Write in the name of the person you have chosen to be your agent to make health care decisions for you if you cannot speak for yourself. Make sure you have talked with them and they are willing to be your agent. This agent may not be your doctor or health care provider.

2. It is important to talk about your general health care wishes with your agent. You may want to write down your wishes. Your agent must follow what you write.

3. Write the same name as in number 1. Include their current address and phone number.

4. You may choose one or more alternate agents. The alternate agent will be used if the person named in number 1 cannot or will not serve. You may leave this blank.

5. Write today's date, month, and year. Write your address. Sign this form while being watched by two witnesses **OR** a notary.

6. There are two ways to make this form legal. You may have it notarized or have it witnessed by two people. To have it notarized, take this form to a notary at your local, bank, hospital, or other agency for their seal. You will sign the form while they watch you. You may need to show identification (driver's license, social security card, or hospital name band).

7. These witnesses may **NOT** be:
   a. a health care provider caring for you at the time you fill out this form;
   b. the person you chose as your agent (Durable Power of Attorney named in number 1);
   c. person under 18 years old; or,
   d. a relative.

8. When the forms are done, give copies to:
   a. your doctor;
   b. your hospital;
   c. your family members;
   d. your minister; and;
   e. keep one for yourself in a safe place that you can get to easily.