DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Designation of Patient Advocate

I, _____, am at least 18 years of age, I am of sound
(Print or type your full name)

mind, and I voluntarily make this designation.

APPOINTMENT OF PATIENT ADVOCATE

I designate _____, my _____
(Insert name of patient advocate) (Relationship to patient advocate)

as my patient advocate. If my first choice cannot serve, I designate _____,
(Name of successor advocate)

my _____, to serve as my patient advocate.
(Relationship to successor advocate)

My patient advocate and/or successor patient advocate must sign an acceptance before he or she can act (Pages 6 – 7). I have discussed this appointment with individuals I have designated as patient advocate and successor patient advocate.

APPOINTMENT OF SUPPORT PERSON (Optional)

A hospital patient has the right to name a support person that s/he wishes to have present with him/her, and who is empowered to exercise the patient's hospital visitation rights on behalf of the patient with respect to other visitors, when the patient is unable to do so. The "support person" may be, but does not have to be, the same person who is named as the patient advocate. The "support person" could be a family member, friend, or other individual who supports the patient during the course of his/her hospital stay. My choice for a support person is _____.

GRANTS OF AUTHORITY AND RESPONSIBILITY

My patient advocate or successor patient advocate shall have power to make care, custody, and medical treatment decisions for me only when I am unable to participate in medical treatment decisions. This designation of patient advocate shall be exercisable when my attending physician and at least one other physician or licensed psychologist determine upon examination that I am unable to participate in medical decisions or, for mental health treatment, when a physician and a mental health professional both certify in writing that I am unable to give informed consent for mental health treatment.

I choose the following physician and/or mental health practitioner to make the determination as to whether I am able to give informed consent for mental health treatment:

_____
_____

I understand that if any of these individuals is unwilling or unable to make this determination within a reasonable time, the required examination and determination may be made by another physician or mental health professional, as appropriate.

[ ] If my religious beliefs prohibit my examination as detailed above, the determination of my inability to participate in medical decisions or give informed consent for mental health treatment shall be made as follows:

_____
_____
_____
_____

In making decisions, my patient advocate shall try to follow my previously expressed desires, instructions, or guidelines given by me orally, in a living will, or in this designation, while I was able to participate in care, custody, or medical treatment decisions.

It is my intent that my family, the medical facility, and any doctors, nurses, and other medical personnel involved in my care shall have no civil or criminal liability for honoring my wishes as expressed in this designation, or for implementing the decisions of my patient advocate. This power of attorney is not affected by my subsequent disability or incapacity, or by the lapse of time.

With respect to my physical and medical treatment, I am granting to my advocate the authorities and responsibilities indicated below. (Check those you are authorizing.)

[ ] Access to and control over my medical records and information.

[ ] Power to employ and discharge physicians, nurses, therapists, and any other care providers, and to pay them reasonable compensation from my funds.

[ ] Power to give informed consent to receiving any medical treatment or diagnostic, surgical, or therapeutic procedure.

[ ] Power to refuse, or to authorize the discontinuance of, any medical treatment, or diagnostic, surgical, or therapeutic procedure.

[ ] Power to arrange medical and personal services for me, including admission to a hospital, nursing care facility, or hospice.

[ ] Power to execute waivers, medical authorizations, and such other approval as may be required to permit or authorize care which I may need, or to discontinue care that I am receiving.

[ ] Power to arrange and consent to inpatient psychiatric hospitalization and treatment as a formal voluntary patient, pursuant to Section 330.1415 of the *Michigan Compiled Laws,* if it is in my best interest and is the least restrictive treatment to protect my safety and/or the safety of others. However, if I am hospitalized as a formal voluntary patient under an application executed by my patient advocate, I retain the right to terminate the hospitalization in accordance with Section 330.1419 of the *Michigan Compiled Laws.*

STATEMENT OF WISHES CONCERNING LIFE-SUSTAINING TREATMENT

I may choose one of the statements below that most represents my wishes, and if I do, I will sign after that choice. If I do not choose one of the statements below, I authorize my patient advocate to make all of my medical decisions. This includes decisions to withhold or withdraw treatment from me that would allow me to die, and I acknowledge that such decisions could or would allow my death.

Choice #1: I do not want life-sustaining treatment (including artificial delivery of food and water) if any of the following medical conditions exist:

a. I am in an irreversible coma or persistent vegetative state.
b. I am terminally ill, and life-sustaining procedures would only serve to artificially delay my death.
c. My medical condition is such that the burdens of treatment outweigh the expected benefits. In making this determination, I want my patient advocate to consider the relief of my suffering, the expenses involved, and the quality of my life, if prolonged.

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment that would allow me to die, and I acknowledge that such decisions could or would allow my death.

[If the statements in Choice #1 reflect your wishes, sign here] _____

Choice #2: I want life-sustaining treatment (including artificial delivery of food and water) unless I am in a coma or vegetative state that my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I do not want life-sustaining treatment (including artificial delivery of food and water) to be provided or continued.

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment that would allow me to die, and I acknowledge that such decisions could or would allow my death.

[If the statements in Choice #2 reflect your wishes, sign here] _____

Choice #3: I want my life to be prolonged to the greatest extent possible consistent with sound medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures. I direct that life-sustaining treatment be provided to prolong my life.

[If the statements in Choice #3 reflect your wishes, sign here] _____

POWER REGARDING ORGAN DONATION (Optional)

[ ] I specifically authorize my patient advocate to donate any of my usable organs/tissues at the time of my death. Therefore, temporary life sustaining measures may be used as part of the donation process as reasonable or necessary to provide usable organs/tissues in as good a condition as possible. The decision to donate usable organs/tissues shall be at the discretion of my patient advocate and shall take into consideration the cost to my estate or family members associated with such donation.

ADDITIONAL WISHES (Optional)

Additional wishes regarding my medical care, mental health care, and/or anatomical donation (you may attach more sheets of paper if necessary). [For mental health care, you may give instructions here about psychiatric hospitalization, alternatives to hospitalization, the use of psychiatric medications, types of therapies, and/or your wishes concerning restraint or seclusion. You may name a person who should be notified upon your admission to the hospital, as well as who should be permitted to visit you.]

_____
_____
_____
_____

Before the powers granted in this designation of patient advocate are exercisable, a copy of it shall be placed in my medical record with my attending physician and, if applicable, with the facility where I am located.

REVOCATION

I retain the right to revoke this designation of patient advocate as to medical treatment at any time, and by any means whereby I may communicate an intent to revoke it.

As to mental health treatment (check one):

[ ] I retain the right to revoke this designation of patient advocate at any time, and by any means whereby I may communicate an intent to revoke it.

[ ] I waive the right to revoke the powers granted in this Patient Advocate Designation regarding mental health treatment decisions. This waiver does not affect the rights afforded to me to terminate formal voluntary hospitalization under Section 330.1419 of the *Michigan Compiled Laws.* Furthermore, if I communicate at a later time that I wish to revoke this Patient Advocate Designation for mental health treatment while I am deemed unable to participate in decisions regarding mental health treatment, and I am receiving mental health treatment at that time, my ability to revoke will be delayed for 30 days.

HIPAA

I intend for my advocate 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 of authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (a/k/a HIPAA), 42 USC 1320d and 45 CFR 160 - 164. I authorize: Any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to: Give, disclose, and release to my advocate, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

Photocopies and facsimile copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

SIGNATURE

I sign this document voluntarily, and I understand its purpose. I am not being required to sign as a condition of providing, withholding, or withdrawing care, custody, or medical treatment.

_____ _____
(Your Signature) (Date)

_____ _____
(Print Name) (Street Address)

_____ _____
(City, State, Zip Code) (Telephone Number)

STATEMENT REGARDING WITNESSES

I have chosen two adult witnesses who are not named in my will; who are not my spouse, parent, child, grandchild, brother or sister; who are not my physician or my patient advocate; who are not an employee of my life or health insurance provider, an employee of a home for the aged where I reside, an employee of a community mental health services program or hospital providing me mental health services, or an employee of a health facility that is treating me.

STATEMENT AND SIGNATURE OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud, or undue influence.

_____ _____
(Witness Signature) (Date)

_____ _____
(Witness Name) (Street Address)

_____ _____
(City, State, Zip Code) (Telephone Number)

_____ _____
(Witness Signature) (Date)

_____ _____
(Witness Name) (Street Address)

_____ _____
(City, State, Zip Code) (Telephone Number)

ACCEPTANCE TO THE DESIGNATION OF PATIENT ADVOCATE

(1) This designation shall not become effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift as described in Public Act 386 of 1998, Section 5506, the authority remains exercisable after the patient's death.

(2) A patient advocate designation is suspended when the patient regains the ability to participate in decisions regarding medical treatment or mental health treatment, as applicable. The suspension is effective as long as the patient is able to participate in those decisions. If the patient subsequently is determined to be unable to participate in decisions regarding medical treatment or mental health treatment, as applicable, the patient advocate's authority, rights, responsibilities, and limitations are again effective.

(3) A patient advocate shall not exercise powers concerning the patient's care, custody, and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.

(4) This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

(5) A patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(6) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

(7) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.

(8) A patient may revoke his or her designation at any time or in any manner sufficient to communicate an intent to revoke.

(9) A patient advocate may revoke his or her acceptance of the patient advocate designation at any time and in any manner sufficient to communicate an intent to revoke.

(10) A patient advocate shall not delegate his or her powers to another individual without prior authorization of the patient.

(11) With regard to mental health treatment decisions, the patient advocate shall only consent to the forced administration of medication or to inpatient hospitalization, other than hospitalization as a formal voluntary patient if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to consent to that treatment.

(12)A patient may waive his or her right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

(13) A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, being Section 333.20201 of the *Michigan Compiled Laws.*

I, the undersigned, understand the above conditions and I accept the designation as patient advocate or

successor patient advocate for _____.
(Name of patient)

I signify that I am 18 years of age or older.

Patient Advocate Signature: _____

Patient Advocate Name: _____ _____
(Date)

Address: _____

_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Successor Patient Advocate Signature: _____

Successor Patient Advocate Name: _____ _____
(Date)

Address: _____

_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Before a patient advocate designation is implemented, a copy of the designation must be given to the proposed patient advocate, and must be given to the successor patient advocate before the successor patient advocate can act as the patient advocate.

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