VERMONT MEDICAL POWER OF ATTORNEY WITH ADVANCE DIRECTIVE

PART I

POWER OF ATTORNEY FOR HEALTH CARE

1. I, _____ (name), presently residing at _____ (address) (the "Principal"), do hereby nominate, constitute, and appoint _____, presently residing at _____, as my true and lawful attorney-in-fact ("agent"), to act for me and in my name, place, and stead, and for my use and benefit for health care purposes.

Agent s phone: _____ Agent s email: _____

Alternative contact information: _____

ALTERNATE AGENT: In the event that _____ (agent s name) resigns, dies, or is otherwise unable or unwilling to so act, then I appoint _____ (alternate agent s name), presently residing at _____ (address), as my substitute agent with the same powers and duties.

Agent s phone: _____ Agent s email: _____

Alternative contact information: _____

If the original agent or a substitute agent is unable to act, then, in such case, one (1) of the following documents shall be attached to this Power of Attorney for Health Care: a resignation or declination to serve signed by the previous agent; a written and signed statement from a licensed physician that the previous named agent is physically or mentally incapable of serving; a certified court order as to the incapacity or inability of the previous named agent to serve; or a certified death certificate of the previous named agent. Third parties who deal with the substitute agent shall be entitled to rely on the original power of attorney instrument, or a photocopy thereof, with any such document attached.

In the event of my incapacity, my agent will have full power and authority to make health care decisions for me, including, but not limited to, the power and authority to do the following:

A. **Consent or Refuse Consent to Medical Care.** To give consent or withhold consent to diagnostic procedures, to medical care, surgery, or any other

medical procedures or tests involving my physical or mental condition; to arrange for my hospitalization, convalescent care, or home care; and to revoke, withdraw, modify, or change consent to such medical care, surgery, or any other medical procedures or tests, hospitalization, convalescent care, or home care, which I or my agent may have previously allowed or consented to which may have been implemented due to emergency conditions.

I ask my agent to be guided in making such decisions by whatever I may have told my agent about my personal preferences regarding such care. Based on those same preferences, my agent may also summon paramedics or other emergency medical personnel and seek emergency treatment, or choose not to do so, as my agent deems appropriate given my wishes and medical status at the time of the decision. My agent is authorized, when dealing with hospitals and physicians, to sign documents titled or purporting to be a "refusal to permit treatment" and "leaving hospital against medical advice," as well as any necessary waivers of or releases of liability required by the hospitals or physicians to implement my wishes regarding medical treatment or non-treatment;

B. Employment of Health Care Personnel. To employ such physicians, dentists, nurses, therapists, and other professionals or non-professionals as my agent may deem necessary or appropriate for my physical or mental well-being; and to pay from my funds reasonable compensation for all services performed by such persons;

C. Gain Access to Medical and Other Personal Information. To request, review, and receive any information, verbal or written, regarding my personal affairs or my physical or mental health, including medical and hospital records, and to execute any releases or other documents that may be required in order to obtain this information;

D. Refuse Extreme Life-Prolonging Procedures. To request that any extraordinary medical care, surgery, procedure, or test designed to artificially prolong my life not be instituted or be discontinued after thirty (30) days. Such extraordinary medical care shall include (but is not limited to) cardiopulmonary resuscitation, the implantation of a cardiac pacemaker, renal dialysis, parenteral feeding, the use of respirators or ventilators, nasogastric tube use, endotracheal tube use, and organ transplants.

My agent should try to discuss the specifics of any such decision with me if I am able to communicate in any manner. If I am unconscious, comatose, senile, or otherwise unreachable by such communication, my agent should make the decision guided by any preferences which I may have previously expressed and the information given to the physician treating me as to my medical diagnosis and prognosis. In making such decisions, I want my agent to consider the relief of suffering and the quality as well as the extent of the possible extension of my life. My agent may specifically request

and concur with the writing of a DNR (do not resuscitate) order by the attending or treating physician;

E. Refuse Nourishment or Hydration. To require, if I have been in an irreversible coma for thirty (30) days or more, as diagnosed by my treating physician, that procedures used to provide me with nourishment and hydration (including, for example, parenteral feeding, intravenous feedings, misting, and endotracheal or nasogastric tube use) not be instituted or, if previously instituted, to require that they be discontinued, but only if my treating physician also determines that I will not experience pain as a result of the withdrawal of nourishment or hydration;

F. Provide Relief from Pain. To consent to and to arrange for the administration of pain-relieving drugs of any type, or other surgical or medical procedures calculated to relieve my pain even though their use may lead to permanent physical damage, addiction, or even hasten the moment of (but not intentionally cause) my death.

My agent may also consent to and arrange for unconventional pain-relief therapy such as biofeedback, guided imagery, relaxation therapy, acupuncture, skin stimulation, or cutaneous stimulation, and other therapies which I or my agent believes may be helpful to me;

G. Blood Transfusions; Organ Transplants and Organ Donations. To refuse to accept a blood transfusion on my behalf as part of any hospital procedure unless either **(i)** I donated the blood myself prior to such procedure or **(ii)** the donated blood has been tested for any and all infectious diseases, specifically, hepatitis and AIDS; to accept organ transplants on my behalf; and to donate my organs for transplant purposes;

H. Arrange Disposition of My Remains. To make arrangements for my funeral and burial, or cremation, as the case may be. My agent shall take into consideration my wishes, including the purchase of the burial plot and marker, and such other related arrangements as my agent deems advisable, being guided by any wishes or preferences which I may have previously expressed;

I. Execute Documents, Enter into Contracts and Pay Reasonable Compensation or Costs in Implementing the Above Powers. To sign, execute, deliver, acknowledge, and make declarations in any document or documents that may be necessary, desirable, convenient, or proper in order to exercise any of the powers described above; to enter into contracts; and to pay from my funds reasonable compensation or costs in the exercise of any such powers; and

J. Personal Care Decisions. To decide about personal care on my behalf, to decide about where I will live, choose my clothing, receive my mail, care for my personal belongings, and care for my pet(s), if any, and to make all other decisions of a personal nature not included in the description of health care.

2. This Health Care Power of Attorney shall become effective only upon the incapacity of the Principal, as determined and evidenced by a written certificate or statement of the Principal's treating physician, stating that the Principal lacks substantial capacity to make informed health care decisions on the Principal's own behalf. The powers granted herein to the agent shall continue notwithstanding such incapacity and shall cease when the Principal is deemed to have regained capacity as determined and evidenced by the written certificate or statement of the attending physician.

When in the process of determining my incapacity (as it relates to this instrument, or any trust agreement or durable general power of attorney executed by me), all individually identifiable health information and medical records may be released under the HIPAA Release Authority granted under Section 3, to the person nominated as my agent, including any written opinion relating to my incapacity that the person so nominated may have requested. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164, and applies even if that person is not yet serving as my agent.

3. I intend for my agent 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 authority applies to any information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (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 professional, any insurance company, 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 agent, 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.

The authority given my agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

4. My agent shall exercise the powers granted under this Power of Attorney in accordance with any instructions set forth in Part II below and my wishes to the extent otherwise known to my agent. To the extent my wishes are unknown, my agent shall exercise the powers granted under this power of attorney in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

5. I hereby ratify and confirm all that my agent shall lawfully do or cause to be done by virtue of this Power of Attorney and hold harmless any person or entity who suffers loss or liability from reliance upon such lawful exercise of this Power of Attorney.

6. If a conservator of my person needs to be appointed for me by a court, I nominate my agent designated in this document. If my agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

7. Only one (1) original of this instrument has been executed. My agent is authorized to make photocopies of this instrument and any attached documents (such as statements of incapacity) as frequently and in such quantities as my agent deems appropriate. Each photocopy shall have the same force and effect as the original, and all parties dealing with my agent are authorized to rely fully on any such photocopy showing the principal's signature thereon.

PART II

ADVANCE HEALTH CARE DIRECTIVE

1. **End-of-Life Decisions.** I request that my health care providers and others involved in my care withhold or withdraw all treatments other than those needed to keep me comfortable, and that I am allowed to die as gently as possible: **(i)** if I am in an irreversible coma or persistent vegetative state, as diagnosed by my treating physician, and have been in such condition for at least thirty (30) days; **(ii)** if I am terminally ill and, in the opinion of my treating physician, the application of life-sustaining procedures would serve only to artificially delay the moment of my death; or **(iii)** under any other circumstances where the burdens of the treatment clearly outweigh the expected benefits.

2. **Relief from Pain.** I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens (but not intentionally causes) my death.

PART III

GENERAL PROVISIONS

1. I revoke all prior powers of attorney for health care (but not durable general powers of attorney for asset management), living wills, and directives to physicians that I may have executed. I retain the right to revoke or amend any portion of this instrument and to substitute other agents in place of the agents appointed in Part I, Section 1 of this instrument.

2. If any of the provisions of this instrument is invalid for any reason, such invalidity shall not affect any of the other provisions of this instrument, and all invalid provisions shall be fully disregarded.

3. All questions pertaining to validity, interpretation, and administration of this instrument shall be determined in accordance with the laws of the state of residence of the Principal.

4. This instrument may be revoked or terminated at any time by the Principal. This instrument will exist for an indefinite period of time unless revoked or terminated.

IN WITNESS WHEREOF, I have hereunto set my hand on _____.

_____
(signature)

_____
(printed name)

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of Vermont)
County _____)

On _____ before me, _____
(here insert name and title of the officer),

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of Vermont that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ **(Seal)**

GENERAL INFORMATION

This document gives the person you designate as your agent (the agent) the power to make health care decisions for you. It also gives you the opportunity to set forth specific instructions regarding your health care. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to the instructions and any other limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent **(1)** authorizes anything that is illegal, **(2)** acts contrary to your known desires, or **(3)** where your desires are not known, does anything that is clearly contrary to your best interests.

This power will exist for an indefinite period of time unless you limit its duration in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to **(1)** authorize an autopsy, **(2)** donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes, and **(3)** direct the disposition of your remains.

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category Medical Power of Attorney Template.

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