

# IDAHO MEDICAL POWER OF ATTORNEY

## 1. DISCLOSURE STATEMENT.

**CAUTION TO THE "PRINCIPAL": YOUR MEDICAL POWER OF ATTORNEY IS AN IMPORTANT DOCUMENT. AS THE "PRINCIPAL", YOU GIVE THE PERSON WHOM YOU CHOOSE (YOUR "AGENT") AUTHORITY TO MAKE MEDICAL DECISIONS ON YOUR BEHALF. BEFORE SIGNING THIS DOCUMENT, READ THE INFORMATION CAREFULLY AND SEEK GUIDANCE FROM A PHYSICIAN OR AN ATTORNEY IF YOU DO NOT FULLY UNDERSTAND ANY OF THE FOLLOWING TERMS AND FACTS:**

**Your agent has the power to make a very broad range of medical decisions for you. Medical decisions can include any medical service, treatment, medical procedure, diagnosis or treatment of both your mental and physical conditions.**

**The person you choose as your agent must be at least eighteen years old or a person under 18 years of age who has had the disabilities of a minority removed. Your agent will have the authority to consent, and to refuse to consent to medical treatment according to your wishes, including decisions about withdrawing or withholding life-sustaining treatment, based on your religious and moral beliefs, when you are no longer capable of making them yourself. Therefore, it is important that the person you appoint as your agent is someone you trust. Your agent should also know your wishes or preferences for your health care treatment.**

**You should inform the person you wish to appoint as the agent that you want the person to be your health care agent. You should make sure that you have chosen an agent that wants to take on the role of agent. You should also discuss this document and your medical preferences with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. You may also choose a backup agent in case your other agent is unavailable to act. Your backup agent should also be aware of your preferences. Even after you sign this document, you will still be able to make your health care decisions assuming you are still considered mentally competent. Your agent cannot act on your behalf until your doctor certifies that you lack the competence to make health care decisions.**

**Your agent is not liable for health care decisions made in good faith on your behalf.**

**You may revoke the authority granted to your agent at any time while you are still competent to do so. The authority granted to your agent will be revoked when you tell your medical provider and your agent, orally or in writing, that you are revoking this medical power of attorney. If you execute another power of attorney later, that will also have the effect of revoking any prior power of attorney. Unless you state otherwise, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void.**

**In order for this document to be valid, it must be signed in accordance with the law of the state where you are signing this document. In general, the medical power of attorney should be signed in the presence of a notary or two witnesses. If you choose to have two witnesses sign, they must be at least 18 and competent. Neither of the two witnesses may be your agent or be related to your agent.**

**This document may not be changed or modified. If you want to make changes in the document, you must execute a new medical power of attorney.**

## **2. DESIGNATION OF AGENT**

I, \_\_\_\_\_, hereby appoint \_\_\_\_\_ of \_\_\_\_\_ as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document or as prohibited by law. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

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## **3. DESIGNATION OF ALTERNATE AGENT.**

An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. I hereby appoint \_\_\_\_\_ of \_\_\_\_\_ as an alternate agent.

## **3. DURATION**

I understand that this power of attorney exists indefinitely from the date I execute this document or until the established end date is reached. However, I may revoke the power of attorney at any moment by notifying my agent orally or in writing. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted to my agent continues to exist until I become able to make healthcare decisions for myself.

[This power of attorney ends on the following date: [MONTH] [DAY], [YEAR]].

## **4. EXECUTION.**

YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES NOT RELATED BY BLOOD OR MARRIAGE.

**5. VALIDITY.**

THIS MEDICAL POWER OF ATTORNEY IS NOT VALID UNLESS:

1. YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR
2. YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

**6. REVOCATION OF PRIOR MEDICAL POWER OF ATTORNEY.**

I hereby revoke or terminate any and all medical power of attorney that have been previously signed by me.

**7. ORIGINAL AND COPIES OF THIS MEDICAL POWER OF ATTORNEY.**

The original of this document will be kept at \_\_\_\_\_ and the following persons and institutions will have signed copies:

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I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in the disclosure statement.

In witness whereof, I have hereunto signed my name this \_\_\_\_\_ day of \_\_\_\_, 20 \_\_\_\_

\_\_\_\_\_  
Signature

**THIS POWER OF ATTORNEY DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.**

I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness: \_\_\_\_\_ Address: \_\_\_\_\_  
Witness: \_\_\_\_\_ Address: \_\_\_\_\_

### NOTARY ACKNOWLEDGMENT

STATE OF \_\_\_\_\_  
COUNTY OF \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_,  
by \_\_\_\_\_

\_\_\_\_\_

Notary Public/Justice of the Peace

My Commission Expires