

OHIO MEDICAL POWER OF ATTORNEY

Disclaimer Statement

This is my Health Care Power of Attorney. I revoke all prior Health Care Powers of Attorney signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I understand that my agent can make health care decisions for me only whenever my attending physician has determined that I have lost the capacity to make informed health care decisions. However, this does not require or imply that a court must declare me incompetent.

Definitions

Several legal and medical terms are used in this document. For convenience, they are explained below.

Agent or attorney-in-fact: The adult I name in this health care power of attorney to make health care decisions for me.

Anatomical gift: A donation of all or part of a human body to take effect upon or after death.

Artificially or technologically supplied nutrition or hydration: The providing of food and fluids through intravenous feedings.

Bond: An insurance policy issued to protect the conservatee's property against theft or loss caused by the conservator's failure to perform his or her duties..

Cardiopulmonary resuscitation or CPR: Treatment to try to restart breathing or heartbeat. CPR can be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving an electric shock to the chest, etc...

Comfort care: Any measure taken to decrease pain or discomfort, but not to postpone death. The Donor Registry Enrollment Form is designed to allow individuals to specifically record their wishes regarding organ, tissue and eye donation in the Ohio Office of Motor Vehicles Donor Registry.

Do Not Resuscitate or DNR Order: A medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

Health care: Any medical procedure, treatment, intervention, or other measure used to maintain, diagnose or treat any physical or mental situation.

Health Care Power of Attorney: In case I am unable to do health care decisions, this document allows me to name an adult person to act as my agent to do so.

Life-sustaining treatment means any health care, including artificially or technologically supplied nutrition and hydration, that primarily serves to prolong the dying process.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

Living Will Declaration or Living Will: Document that allows me to specify the medical care I want to receive in case i am terminally ill or permanently unconscious and unable to make my wishes known.

Permanently unconscious state: an irreversible condition in which I am permanently unaware of myself and surroundings.

Principal: the person who sign this document.

Terminal condition or terminal illness: an irreversible, incurable and untreatable condition caused by disease, illness or injury.

1. 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.

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.

Authority of Agent.

My agent has full and complete authority to make all health care decisions for me whenever I cannot make such decisions, unless I have otherwise indicated below. This authority includes, but is not limited to, the following:

1. To consent to the administration of pain-relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death. My comfort and freedom from pain are important to me and should be protected by my agent and physician.
2. If I am in a terminal condition, to give, to withdraw or to refuse to give informed consent to life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.

3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, intervention or other measure.
4. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all my medical and health care records.
5. To consent to further disclosure of information, and to disclose medical and related information concerning my condition and treatment to other persons.
6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.
7. To execute consents, waivers, and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any third party who acts under this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.
8. To select, employ, and discharge health care personnel and services providing home health care and the like.
9. To select, contract for my admission to, transfer me to, or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.
10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, should I become unable to make health care decisions for myself in a place where this document is not enforced.
11. To complete and sign for me the following:
 - (a) Consents to health care treatment, or the issuance of Do Not Resuscitate (DNR) Orders or other similar orders; and
 - (b) Requests for my transfer to another facility, to be discharged against health care advice, or other similar requests; and
 - (c) Any other document desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

Special Instructions. By placing my initials at number 3 below, I want to specifically authorize my agent to refuse, or if treatment has commenced, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration if:

1. I am in a permanently unconscious state; and
2. My physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain; and
3. I have placed my initials on this line: _____

2. 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]].

3. 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.

4. 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.

5. 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