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**HEALTH CARE POWER OF ATTORNEY**

**OF**

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# HEALTH CARE POWER OF ATTORNEY

## DESIGNATION OF PATIENT ADVOCATE

**TO MY FAMILY, DOCTORS AND ALL CONCERNED WITH MY CARE:**

These instructions express my wishes about my health care. I want my family, doctors, and everyone else concerned with my care to act in accord with them.

### **1. Appointment of Patient Advocate**

I appoint the following person my Patient Advocate:

Patient Advocate's Name: \_\_\_\_\_

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

### **2. Appointment of Successor Patient Advocate**

I appoint the following person my successor Patient Advocate if my Patient Advocate does not accept my appointment, is incapacitated, resigns or is removed. My successor Patient Advocate is to have the same powers and rights as my Patient Advocate.

Name: \_\_\_\_\_  
*[Successor]*

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

My Patient Advocate may delegate her powers to the successor Patient Advocate if she is unable to act.

My Patient Advocate or successor Patient Advocate may only act if I am unable to participate in making decisions regarding my medical treatment.

### **3. Instructions for Care**

My Patient Advocate shall have the authority to make all decisions and to take all actions regarding my care, custody and medical treatment, including, but not limited to the following:

- a. Have access to, obtain copies of and authorize release of my medical and other personal information.
- b. Employ and discharge physicians, nurses, therapists, and any other health care providers, and arrange to pay them reasonable compensation.
- c. Consent to, refuse or withdraw for me any medical care; diagnostic, surgical, or therapeutic procedure; or other treatment of any type or nature, including life-sustaining treatments. I understand that life sustaining treatment includes, but is not limited to breathing with the use of a machine and receiving food, water and other liquids through tubes. I also understand that these decisions could or would allow me to die. I have listed below any specific instructions I have related to life-sustaining treatments.

My Patient Advocate is to be guided in making medical decisions for me by what I have told him/her about my personal preferences regarding my care. I understand that this decision could or would allow me to die.

#### **4. Effect**

This document is to be treated as a Durable Power of Attorney for Health Care and shall survive my disability or incapacity.

#### **5. HIPAA Release Authority**

This instrument is meant to be an unlimited, full and complete authorization for the release of any and all protected medical information as defined under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 42 USC 1320d and 45 CFR 160-164, as amended, and under the rules and regulations thereunder, and covers all protected information. It is understood that my Patient Advocate to whom this authorization is given has my permission to use and disseminate this information in my Patient Advocate’s sole discretion.

- a. I intend for my Patient 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 authority applies to any information governed by HIPAA.
- b. 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 Patient Advocate, without restriction, all my individually identifiable health

information and medical records, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

- c. The authority given my Patient Advocate 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.
- d. The authority given my Patient Advocate 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.

**6. Miscellaneous Provisions**

If I am unable to participate in making decisions for my care and there is no Patient Advocate or successor Patient Advocate able to act for me, I request that the instructions I have given in this document be followed and that this document be treated as conclusive evidence of my wishes.

It is also my intent that anyone participating in my medical treatment shall not be liable for following the directions of my Patient Advocate that are consistent with my instructions.

This document is signed in the State of Michigan. It is my intent that the laws of the State of Michigan govern all questions concerning its validity, the interpretation of its provisions and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be.

I hereby revoke any and all prior Health Care Powers of Attorney executed by me.

Photocopies of this document can be relied upon as though they were originals.

I am providing these instructions of my free will. I have not been required to give them in order to receive or have care withheld or withdrawn. I am at least eighteen (18) years old and of sound mind.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

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

\_\_\_\_\_

**Witness Statement and Signature**

I declare that the person who signed this Designation of Patient Advocate signed it in my presence and is known to me. I also declare that the person who signed appears to be of sound mind and under no duress, fraud, or undue influence and is not my husband or wife, parent, child, grandparent, brother or sister. I declare that I am not the presumptive heir of the person who signed this document, the known beneficiary of her will at the time of witnessing, her physician or a person named as the Patient Advocate. I also declare that I am not an employee of a life or health insurance provider for the person who signed, an employee of a health facility that is treating her, or an employee of a home for the aged where she resides and that I am at least eighteen (18) years old.

***WITNESSES:***

\_\_\_\_\_

\_\_\_\_\_

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

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

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## ACCEPTANCE OF PATIENT ADVOCATE

I agree to be the Patient Advocate for \_\_\_\_\_ (called "Patient" in the rest of this document). I accept the Patient's designation of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the Patient as indicated in the Designation of Patient Advocate, in other written instructions of the Patient and as we have discussed verbally.

I also understand and agree that:

- a. This designation shall not become effective unless the Patient is unable to participate in medical treatment decisions.
- b. A Patient Advocate shall not exercise powers concerning the Patient's care, custody, and medical treatment that the Patient, if the Patient were able to participate in the decision, could not have exercised on his or her own behalf.
- c. 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.
- d. 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.
- e. 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.
- f. 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 treatment decisions are presumed to be in the Patient's best interests.
- g. A Patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.
- h. A Patient Advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

- i. 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.

If I am unable to act after reasonable effort to contact me, I delegate my authority to the person the Patient has designated as successor Patient Advocate. The successor Patient Advocate is authorized to act until I become available to act.

***PATIENT ADVOCATE***

\_\_\_\_\_

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

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

***Successor PATIENT ADVOCATE***

\_\_\_\_\_

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

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

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