**MEDICAL POWER OF ATTORNEY**

**IMPORTANT INFORMATION**

IT IS IMPORTANT THAT YOU REVIEW THE FOLLOWING INFORMATION BEFORE YOU SIGN THIS DOCUMENT. READ THE INFORMATION CAREFULLY AND SEEK GUIDANCE FROM A HEALTHCARE PROFESSIONAL OR ATTORNEY IF YOU DO NOT UNDERSTAND ANY OF THE TERMS.

By signing this document, you are giving authority to the person you are designating as your Agent to make medical decisions on your behalf. Medical decisions can include any medical service, treatment, medical procedure, diagnosis or treat both mental and physical conditions. Your Agent will be able to act with the same authority you would have if you were able to act for yourself and will have the authority to consent and refuse to consent to medical treatment. It is, therefore, important that you know and trust your agent and that your agent is aware of your preferences for health care treatment.

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 physician has determined that you are no longer physically or mentally able to make medical decisions unless otherwise stated in this document.

The person you choose as your agent must be at least eighteen years old and someone that you trust with your health care. Your agent is not liable for any decisions they make on your behalf, as long as those decisions were made in good faith. You should make sure that you have chosen agent wants to take on the role as agent. Discuss your medical preferences with your agent so they are aware of your wishes. Review this document with your agent so they are aware of their role. You also may choose up to two (2) Alternate Agents in case your main Agent is unavailable to act. Your Alternate Agent(s) should also be over 18 and aware of your preferences.

You may revoke this document at any time while you are still competent to do so. You may revoke it by telling your medical provider and your agent that you are revoking the document or you may provide them a written revocation (Recommended). If you execute another power of attorney later, that will have the effect of revoking this one.

In order for this document to be valid, it must be signed in the presence of a notary or two (2) witnesses. If you choose to have two witnesses sign, they must be at least 18, competent and independent and not your agent or related to your agent.

**PART I. APPOINTMENT OF HEALTH CARE AGENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hereinafter known as the “Principal”) hereby appoint, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (hereinafter known as the “Agent”) as my Agent to make any and all medical decisions on my behalf, except to the extent that I limit in this document. My Agent can be reached at the following contact information:

**Home Phone**: N/A **Work Phone**: N/A

**Cell Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**E-Mail**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPOINTMENT OF ALTERNATE AGENT(S)**

If my Agent appointed above is unable or unwilling to serve, there shall be no other individuals authorized to make medical decisions on my behalf.

**LIMITATIONS OF MY AGENT**

**Initial**

\_\_\_\_\_\_\_ - I intend for my agent to be treated as I would with respect to my rights regarding the use and disclosure of my individually identifiable health information or medical records. This release authority applies to information governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 USC 1320d, 45 CFR 160-164.

**DURATION**

Unless stated otherwise herein, this document shall remain in effect until I revoke it. I understand that I cannot revoke this document during the time I am considered incompetent to make my own decisions.

**Initial**

\_\_\_\_\_\_\_ - This document shall not have an end date and shall terminate upon revocation, a new medical power of attorney, or my death.

**WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE**

My Agent's authority becomes effective (Initial Below):

**Initial**

\_\_\_\_\_\_\_ - Immediately to make health care decisions on my behalf.

**AGENT'S OBLIGATION**

My Agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part II of this form, and my other wishes to the extent known to my Agent. To the extent my wishes are unknown, my Agent shall make health care decisions for me 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.

**AGENT'S POSTDEATH AUTHORITY**

**Initial**

\_\_\_\_\_\_\_ - My Agent is not authorized to make anatomical gifts, authorize an autopsy, or the direct disposition of my remains, except as I state in Part III of this form.

**PRIOR MEDICAL POWER OF ATTORNEY**

By signing this document, I hereby revoke any and all prior medical powers of attorney that I may have executed.

**PART II. LIVING WILL**

**Initial**

\_\_\_\_\_\_\_ - I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, declare to not elect having a Living Will as part of my Medical Power of Attorney Form.

**PART III. DONATION OF ORGANS**

**Initial**

\_\_\_\_\_\_\_ - I do not wish to donate any of my organs after my death.

**PART IV. PRIMARY CARE PHYSICIAN**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, wish to enter my Primary Care Physician's information as detailed below:

**Primary Care Physician**: Douglas Shoenberger with an office location of 101 S Main Street, Suite 101, Coopersburg, Pennsylvania, 18036 **Telephone**: (610) 282-1170

**ORIGINAL AND COPIES OF THIS DOCUMENT**

This original document and/or copies shall be kept at the following locations: Coopersburg Family Practice

**GOVERNING LAW**

This document shall be governed by the State where the Principal resides.

**EXECUTION**

You must initial, date, and sign this power of attorney before two (2) witnesses not related by blood or marriage.

**Principal’s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Principal’s Name

**Agent’s Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agent’s Name

**WITNESS STATEMENT AND ACKNOWLEDGMENT**

I am not the person appointed as agent or successor agent in this medical power of attorney. I am not related to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_by blood or marriage. I am not entitled to any portion of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ estate, nor do I have any claim against their estate. I am not the attending physician of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or an employee of the attending physician. I am not involved in providing direct patient care to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

**SIGNATURE OF FIRST WITNESS**

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

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

**SIGNATURE OF SECOND WITNESS**

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

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