Indiana Power of Attorney for Health Care Decisions and Appointment of Health Care Representative

I, Name, of Address Address, hereby appoint Name of attorney-in-fact of Address with the following contact information: Home telephone number / Work telephone number, as my attorney-in-fact to make health care decisions on my behalf whenever I am incapable of making my own health care decisions.

I. I grant my attorney-in-fact the following powers in matters affecting my health care:

1. to employ or contract with servants, companions, or health care providers involved in my health care;
2. to consent to or refuse any health care, treatment, service, or procedure to maintain, diagnose, treat, or not to treat my physical or mental conditions;
3. to consent to my admission or release me from a hospital or health care facility;
4. to have access to my records, including medical records, concerning my condition;
5. to make anatomical gifts on my behalf;
6. to request an autopsy; and
7. to make plans for the disposition of my body.

II. In the event the person I appoint above is unable, unwilling, or unavailable to act as my attorney-in-fact, I hereby appoint: Name of successor attorney-in-fact of Address with the following contact information: Home telephone number / Work telephone number, as my successor attorney-in-fact.

Executed this Day day of Month, Year.

Signed: Your Signature

Printed Name: Your Printed Name

Witness Signature (an adult other than the Health Care Representative):

Printed name of Witness: Witness's Printed Name

Date: Date

Appointment of My Attorney-In-Fact as My Health Care Representative; Decisions Regarding Withdrawing or Withholding Health Care

In addition to the powers granted above, I appoint my attorney-in-fact as my health care representative and authorize my attorney-in-fact and health care representative to make decisions in my best interest concerning the consent, withdrawal, or withholding of health care. I understand health care to include any medical care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental well-being.

Health care also includes the providing of nutrition and hydration through intravenous, gastrostomy, or nasogastric tubes. If, at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent they are available.

The authority granted herein shall become effective when my attending physician determines that I am incapable of consent and is not effective while I am capable of consent.
I hereby designate my Health Care Representative as my personal representative with respect to all medical information, including protected health information as defined and governed by the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations thereunder. This provision of this Appointment of Health Care Representative is effective upon execution and is not affected by subsequent incapacity.

If my Health Care Representative resigns or is unwilling to comply with this written appointment, such Health Care Representative may not exercise further power under this appointment and shall so inform me or my legal representative, if unknown, and my health care provider, if known.

I reserve the right to revoke this Appointment at any time by oral or written notice to my Health Care Representative and to revoke the authority granted to my Health Care Representative by oral or written notice to my health care provider.

Executed this Day day of Month, Year

Signed: Your Signature

Printed Name: Your Printed Name

Witness Signature (an adult other than the Health Care Representative):

Printed name of Witness: Witness' Printed Name

Date: Date

Subscribed and acknowledged before me by Your Name,

the principal, this Day day of Month, Year

Notary Public

My Commission expires Expiration Date