# DURABLE POWER OF ATTORNEY
# FOR HEALTH CARE

I, _____, am of sound mind and I
(Print or type your full name)
voluntarily make this designation.

## APPOINTMENT OF PATIENT ADVOCATE

I designate _____, my _____
(Insert name of patient advocate) (Spouse, child, friend, etc.)
living at _____
(Address of patient advocate)
as my patient advocate. If my first choice cannot serve, I designate _____, my _____, living at
(Name of successor patient advocate) (Spouse, child, friend, etc.)
_____
(Address of successor patient advocate)
to serve as patient advocate.

I have discussed this appointment with the individuals I have designated as patient advocate and successor patient advocate.

## GENERAL POWERS

My patient advocate or successor patient advocate shall have power to make care, custody and medical treatment decisions for me if my attending physician and another physician or licensed psychologist determine I am unable to participate in medical treatment decisions.

In making decisions, my patient advocate shall try to follow my previously expressed wishes, whether I have stated them orally, in a living will, or in this designation.

My patient advocate has authority to consent to or refuse treatment on my behalf, to arrange medical and personal services for me, including admission to a hospital or nursing care facility, and to pay for such services with my funds.

My patient advocate shall have access to any of my medical records to which I have a right. This shall serve as a release under the Health Insurance Portability and Accountability Act.

My patient advocate shall have access to my birth certificate and other legal documents needed to apply for Medicare, Medicaid, and other government programs.

**POWER REGARDING LIFE-SUSTAINING TREATMENT**

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my death. My patient advocate can sign a do-not-resuscitate declaration for me. My patient advocate can refuse food and water administered to me through tubes.

_____

(Sign your name if you wish to give your patient advocate this authority)

My desires concerning medical treatment are (if none, write "none") -

_____

_____

_____

_____

_____

My family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability for following my wishes as expressed in this declaration.

I may change my mind at any time by communicating in any manner that this declaration does not reflect my wishes.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

**SIGNATURE**

I sign this document voluntarily and after careful consideration. I understand its meaning and I accept its consequences.

Dated: _____

Signed: _____

(Your signature)

_____

(Address)

I have chosen two adult witnesses who are not named in my will; who are not my spouse, parent, child, grandchild, brother or sister; who are not my physician or my patient advocate; who are not an employee of my life or health insurance company, an employee of a home for the aged where I reside, an employee of community mental health program providing me services or an employee at the health care facility where I am now.

## STATEMENT AND SIGNATURE OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____ _____

(Print name) (Signature of witness)

_____

(Address)

_____ _____

(Print name) (Signature of witness)

_____

(Address)

**Template adapted from the Michigan State Long Term Care Ombudsman Program. This document is for your information and is not designed to replace the counsel of your attorney.**

## ACCEPTANCE BY PATIENT ADVOCATE

**(1) This designation shall not become effective** unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift as described in section 5506, the authority remains exercisable after the patient's death.

**(2) A patient advocate shall not exercise powers** concerning the patient's care, custody and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

**(3) 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.

**(4) 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.

**(5) 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.

**(6) 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 or mental heath treatment decisions are presumed to be in the patient's best interests.

**(7) A patient may revoke his or her designation** at any time or in any manner sufficient to communicate an intent to revoke.

**(8) A patient may waive his or her right to revoke** the patient advocate designation as to the power to make mental health treatment decisions, and if such waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

**(9) 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.

**(10) 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.

I, _____, understand the above
(Name of patient advocate)
conditions and I accept the designation as patient advocate or successor patient advocate for _____, who signed a
(Name of patient)
durable power of attorney for health care on the following date: _____.

***Dated:*** _____

***Signed:*** _____
(Signature of patient advocate or successor patient advocate)