

Temple Physicians

Durable Power of Attorney for Health Care

1. Designation of Surrogate

I understand my right to make my own decisions to accept or refuse health care treatments. If I become unable to make a treatment decision,

I appoint:

Name _____

Address _____

Telephone _____ Relationship _____

as my Attorney-in-fact (or “Surrogate”) for health care decisions.

If she/he cannot be reached, or is unable or unwilling to make the decision, I appoint these people in the following order as substitute surrogates with the same powers:

Name of First Substitute Surrogate _____

Address _____

Telephone _____ Relationship _____

Name of Second Substitute Surrogate _____

Address _____

Telephone _____ Relationship _____

2. **Surrogate's Powers**

If I become unable to make health care treatment decisions, I grant to my Surrogate authority to make health care treatment decisions, including but not limited to:

- A. Consent to, refuse, or withdraw, any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;
- B. Have access to medical records and information to the same extent that I am entitled, including the right to disclose the contents to others as authorized by law;
- C. Authorize or refuse my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service;
- D. Authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death;
- E. Take any other act necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, physician, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice.

I have had the opportunity to get any and all advice before making this appointment. I am doing so freely, and release my physician from any liability which may result from this appointment or from decisions of the Surrogate.

Dated _____

Signature of Appointor

Print Name

Witnesses:

Signature

Print Name

Signature

Print Name

3. Surrogate's Acceptance of Appointment

I hereby accept the appointment as Surrogate for health care decisions for _____
_____ (the "Appointor"). In accordance with the terms
of the Durable Power of Attorney for Health Care, I accept responsibility to:

- A. Make treatment decisions based on what the Appointor would have wanted if he/she were able to decide.
- B. Abide by any advance directives previously communicated by the Appointor, even if I would not have chosen the same course.
- C. Include the Appointor in any treatment decisions to the fullest extent of his/her decision-making capacity.
- D. Notify all members of the immediate family and any interested family of my appointment, and communicate with them regarding treatment decisions. If any of these relatives contests my appointment, I will inform the Administrator of the disagreement.

I have had the opportunity to receive any and all advice before accepting this appointment. I accept it freely, and release my physician of any liability resulting from my appointment or decisions that I make.

Surrogate:

_____ <i>Signature</i>	_____ <i>Print Name</i>
_____ <i>Relationship to Patient</i>	_____ <i>Telephone</i>

First Substitute Surrogate (if available):

_____ <i>Signature</i>	_____ <i>Print Name</i>
_____ <i>Relationship to Patient</i>	_____ <i>Telephone</i>

Second Substitute Surrogate (if available):

_____ <i>Signature</i>	_____ <i>Print Name</i>
_____ <i>Relationship to Patient</i>	_____ <i>Telephone</i>

Witness _____