

## **Section IV: Designation of Health Care Power of Attorney**

A Health Care Power of Attorney is a person you have designated to make health care choices for you. This should be a person you know and trust to act in accordance with your requests. This person is referred to as your health care agent. You decide what choices your agent may make, when your agent may make those choices and how you want your agent to make your choices through the choices you have expressed in your living will.

Your health care agent is usually an adult (18 years of age or older) who you know well and can be trusted to honor your choices. This person must be able to make difficult choices under stressful circumstances and honor the choices you have expressed.

You may make a combined directive that includes both a living will and a health care power of attorney.

In the event you have not designated a health care agent, a health care representative may speak on your behalf. A health care representative may make health care choices for you if you become incompetent **and** you have:

- No living will with applicable instructions
- No available health care agent, **and**
- No legal guardian to make health choices for you

Pennsylvania law allows you to choose your health care representative while you are of sound mind. You need to put your choice in writing or tell you health care providers so they can document your wishes and choices.

### **Health Care Representative list:**

1. Spouse (unless one of you has filed for divorce) and adult child from a different relationship
2. Adult child
3. Parent
4. Adult brother or sister
5. Adult grandchild
6. Adult who is familiar with what you would want

If you do not name a health care representative, Pennsylvania health care providers generally must use someone from the health care representative list. Choices are made in the order listed above.

It is usually better to name a health care agent in a health care power of attorney instead of relying on a health care representative to speak for you. By planning in advance, you will ensure that the person who speaks for you will make the choices you would have made.

**DOYLESTOWN HOSPITAL**

DOYLESTOWN, PA

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

### Healthcare Power of Attorney

I, \_\_\_\_\_,  
want to name, \_\_\_\_\_ to be my health care agent  
through my Health Care Power of Attorney. This agent will be able to make health care  
choices that were expressed in my living will.

Effective immediately and continuously until my death or revocation by a writing signed  
by me or someone authorized to make health care treatment decisions for me, I authorize  
all health care providers or other covered entities to disclose to my health care agent,  
upon my agent's request, any information, oral or written, regarding my physical or  
mental health, including, but not limited to, medical and hospital records and what is  
otherwise private, privileged, protected or personal health information, such as health  
information as defined and described in the Health Insurance Portability and  
Accountability Act of 1996 (Public Law 104-191, 110, Stat. 1936), the regulations  
promulgated there under and any other State or local laws and rules. Information  
disclosed by a health care provider or other covered entity may be redisclosed and may  
no longer be subject to the privacy rules provided by 45 C.F. R. Pt. 164.

The remainder of this document will take effect when and only when I lack the ability to  
understand, make or communicate a choice regarding a health or personal care decision  
as verified by my attending physician. My health care agent may not delegate the  
authority to make decisions.

MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS SUBJECT  
TO THE HEALTH CARE TREATMENT INSTRUCTIONS THAT FOLLOW IN PART  
III (CROSS OUT ANY POWERS YOU DO NOT WANT TO GIVE YOUR health care  
AGENT):

1. To authorize, withhold or withdraw medical care and surgical procedures.
2. To authorize, withhold or withdraw nutrition (food) or hydration (water)  
medically supplied by tube through my nose, stomach, intestines, arteries or  
veins.
3. To authorize my admission to or discharge from a medical, nursing, residential or  
similar facility and to make agreements for my care and health insurance for my  
care, including hospice and/or palliative care.
4. To hire and fire medical, social service and other support personnel responsible  
for my care.
5. To take any legal action necessary to do what I have directed.

6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

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

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_ Telephone #: \_\_\_\_\_ (W) (H) (C)

Name of Healthcare Agent: \_\_\_\_\_ Date: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_ Telephone #: \_\_\_\_\_ (W) (H) (C)

Alternate Healthcare Agent: \_\_\_\_\_ Date: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_ Telephone #: \_\_\_\_\_ (W) (H) (C)

Witness # 1: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Witness # 2: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_