General Statement of Authority Granted

I, _____, designate and appoint:

Name: _____
Address: _____
_____
Phone Numbers: _____
E-mail: _____

to be my agent for health care decisions and pursuant to the language stated below, on my behalf to:

(1) grant consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, and to make decisions about organ donation, autopsy and disposition of my body;

(2) make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care as the agent shall deem necessary for my physical, mental and emotional well-being; and

(3) request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute any releases of other documents that may be required in order to obtain such information and, in this regard,

(a) I intend that my agent be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records, including any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164, as amended from time to time or any similar legislation;

(b) I authorize any of the persons described in paragraph (2) above as well as any health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company, any health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services to give, disclose and release to my agent, without restrictions, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including but not limited to mental illness and drug and alcohol abuse; and

(c) I intend that this authority given my agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information and has no expiration date unless I revoke such authority in writing and deliver it to my health care provider.

In exercising the grant of authority set forth above, my agent for health care decisions shall be guided by and honor the provisions of that certain **Advance Declaration on Life & Natural Death** ("Declaration"), if I have executed one. In the event that any provision hereof shall conflict with such Declaration, the Declaration shall control.

Limitations of Authority

(1) The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for healthcare decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.

(2) The agent shall be prohibited from authorizing consent for the following items:

_____

(3) This durable power of attorney for health care decisions shall be subject to the additional following limitations:

_____

Effective Time

This power of attorney for health care decisions shall become effective upon and remain in effect during the occurrence of my disability or incapacity as determined by the physician selected by or assigned to me, who has the primary responsibility for my treatment and care.

Revocation

Any durable power of attorney for health care decisions I have previously made is hereby revoked.

This durable power of attorney for health care decisions shall be revoked solely by an instrument in writing, executed, witnessed or acknowledged in the same manner as required herein for its execution.

Alternate Agent for Health Care Decisions

If my agent _____ is unavailable or unwilling to make health care decisions for me, is deceased or becomes incapacitated (as determined by certification by a licensed physician), then I appoint

Name: _____

Address: _____

_____

Phone Numbers: _____

E-mail: _____

as my agent for health care decisions with all of the same powers granted to the original appointed agent for health care decisions.

Execution

Executed this_____day of_____, 20____at_____, Kansas.

_____
Signature

STATE OF _____) COUNTY OF _____) SS

This instrument was acknowledged before me on _____, 20____,

by _____

_____
Notary Public

My Appointment Expires:

References:
K.S.A. §58-632
Ethical and Religious Directives for Catholic Health Care Services, 6th Ed.
(U.S. Conference of Catholic Bishops, 2018, www.usccb.org/about/doctrine/ethical-and-religious-directives/index.cfm)