DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS
GENERAL STATEMENT OF AUTHORITY GRANTED

I, _____, designate and appoint:

Name: _____

Address: _____

_____

Telephone Number: _____

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

(1) 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 the 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.

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 **Catholic Declaration on Life & Natural Death** ("Declaration") which I have executed. 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 health care decisions, and shall not include the power to revoke or invalidate the Declaration.

(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 (CHECK ONE BOX):

☐ immediately and shall not be affected by my subsequent disability or incapacity;

or

☐ upon the occurrence of my disability or incapacity as determined by two physicians, one whom shall be my treating physician.

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 by an instrument in writing executed, witnessed or acknowledged in the same manner as required herein.

EXECUTION

Executed this ____ day of _____, 200__ at _____, Kansas.

_____
Principal

NOTE: This document must be: (1) witnessed by two individuals of lawful age who are not the agent, not related to the principal by blood, marriage or adoption, not entitled to any portion of principal's estate and not financially responsible for principal's health care; **OR** (2) acknowledged by a notary public.

_____	_____
Witness	Witness
_____	_____
Address	Address

(OR)

STATE OF _____)
) SS.
COUNTY OF _____)

This instrument was acknowledged before me on _____ by
(date)
_____.
(Principal)

_____
Notary Public

My appointment expires:

Reference: K.S.A. §58-632 (2005)