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How to Complete Your Arizona Health Care Power of Attorney

Health Care Power of Attorney • A.R.S. §§ 36-3221 to 36-3224

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. This form lets you name a health care agent to make medical decisions for you if you cannot make or communicate them yourself. It follows Arizona's sample form and includes optional choices about autopsy, organ donation and funeral arrangements. It does not cover money; for that, use a Durable Power of Attorney.

1. **Name your agent and a successor (Part 1)**
   Your agent should know your wishes and be willing to serve.
2. **Initial your choices**
   Living will attached or not, autopsy and organ donation are optional.
3. **Add instructions (Parts 4–5, optional)**
   Funeral wishes, limits or religious preferences.
4. **Sign before a notary or one qualified witness**
   Use one or the other. We recommend a notary: it avoids witness disqualification problems and is widely accepted.

Signing requirements: Arizona requires a notary **or** one adult witness. The notary or witness cannot be your agent or anyone involved in your health care; a single witness also cannot be related to you or an heir (A.R.S. § 36-3221).

After It's Signed

- Give copies to your agent, your doctors and your hospital.
- You may also register it with the Arizona Health Care Directives Registry so providers can find it.

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Have questions about your Health Care Power of Attorney? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**.

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HEALTH CARE POWER OF ATTORNEY

State of Arizona • A.R.S. §§ 36-3221 to 36-3224 • Based on the sample form in § 36-3224

1. HEALTH CARE POWER OF ATTORNEY

Principal full name

I, the principal named above, designate the following person as my agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

Agent name | Relationship | Phone

Agent address

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint the following person as my agent:

Successor agent name | Relationship | Phone

Successor agent address

I have / I have not (initial one) completed and attached a living will for purposes of providing specific direction to my agent in situations that may occur during any period when I am unable to make or communicate health care decisions or after my death. My agent is directed to implement those choices I have initialed in the living will.

☐ I have attached a living will.

☐ I have not attached a living will.

I have / I have not (initial one) completed a prehospital medical care directive pursuant to A.R.S. § 36-3251.

☐ I have completed a prehospital medical care directive.

☐ I have not.

This health care directive is made under A.R.S. § 36-3221 and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

2. AUTOPSY (optional; under Arizona law an autopsy may be required)

☐ I do not consent to an autopsy.

☐ I consent to an autopsy.

☐ My agent may give consent to or refuse an autopsy.

3. ORGAN DONATION (optional)

If you do not initial any statement, your agent and your family will have the authority to make a gift of all or part of your body under Arizona law.

☐ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

☐ I have already signed a written agreement or donor card regarding organ and tissue donation.

☐ Under Arizona law, I give, effective on my death, any needed organs or parts, or the parts listed below, for any legally authorized purpose or (if written below) for transplant or therapeutic purposes only:

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4. FUNERAL AND DISPOSITION OF REMAINS (optional)

My agent may make arrangements for my funeral and the disposition of my remains, subject to these instructions:

5. ADDITIONAL INSTRUCTIONS OR LIMITATIONS (optional)

SIGNATURE OF PRINCIPAL

Do not date or sign until your notary or witness is present.

X _____ Principal signature (or mark)

Date

Principal address

VERIFICATION BY NOTARY OR WITNESS

Use **one** of the two options below: a notary public (Option A) **or** one qualified adult witness (Option B). Arizona law (A.R.S. § 36-3221) requires one or the other. The undersigned affirm(s) that the notary or witness was present when the principal dated and signed or marked this health care power of attorney, and that the principal appeared to be of sound mind and free from duress at the time of execution. The notary or witness further affirms that he or she is not: (1) under eighteen years of age; (2) designated to make medical decisions on the principal's behalf; or (3) directly involved with the provision of health care to the principal at the time this health care power of attorney is executed. If only one witness signs, that witness also affirms that he or she is not related to the principal by blood, marriage or adoption and is not entitled to any part of the principal's estate by will or by operation of law.

OPTION A — NOTARY ACKNOWLEDGMENT

STATE OF ARIZONA

COUNTY OF

On this _____ day of _____, 20____, before me personally appeared _____, the principal, who signed this health care power of attorney in my presence. I affirm the statements in the verification paragraph above.

X _____ Signature of Notary Public

(Notary seal)

Notary Public (printed name)

My commission expires

Commission number

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Option B — Statement of witness

I affirm under penalty of perjury the statements in the verification paragraph above.

X _____ Date _____

Witness signature

Witness printed name _____ Witness address _____

IF THE PRINCIPAL IS PHYSICALLY UNABLE TO SIGN OR MARK

The notary or witness verifies that the principal directly indicated that this health care power of attorney expresses the principal's wishes and that the principal intends to adopt it at this time.

X _____ Date _____

Signature of notary or witness

ACKNOWLEDGMENT OF AGENT (optional)

By accepting or acting under the appointment, the agent assumes the legal responsibilities of an agent.

X _____ Date _____

Agent signature

Agent printed name _____

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