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How to Complete Your Ohio Health Care Power of Attorney

Durable Power of Attorney for Health Care (R.C. 1337.11 to 1337.17)

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

About this form. An Ohio health care power of attorney names someone (your "attorney in fact") to make **health care decisions** for you if you lose the capacity to decide. It does **not** cover finances.

1. **Read the required Notice (Pages 1–3)**
   Ohio requires this Notice on every printed form. It explains the limits on your agent's authority.
2. **Name your agent and alternates (Page 4)**
   Initial the nutrition and hydration statement only if you agree with it.
3. **Limits and signing (Pages 5–6)**
   Add any limitations, then sign in ONE of two ways: before **two qualified adult witnesses** or before a **notary** (Page 6). Many people choose the notary because witnesses must meet strict rules. We can also provide witnesses for an additional fee.

After It's Signed

- Give copies to your agent, alternates, doctor, and hospital. A copy is as valid as the original.
- Consider also an Ohio Living Will Declaration and a HIPAA Authorization. We have free forms for both.

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Have questions about this document? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**. Attorneys licensed in California, Nevada, and other states.

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NOTICE TO ADULT EXECUTING THIS DOCUMENT

(Required by Ohio Revised Code 1337.17)

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make **MOST*** health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact **GENERALLY*** will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you **GENERALLY*** will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER*, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact **NEVER*** will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

(a) You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). **(YOU SHOULD UNDERSTAND THAT COMFORT CARE IS DEFINED IN OHIO LAW TO MEAN ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) WHEN ADMINISTERED TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH, AND ANY OTHER MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE THAT WOULD BE TAKEN TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH. CONSEQUENTLY, IF YOUR ATTENDING PHYSICIAN WERE TO DETERMINE THAT A PREVIOUSLY DESCRIBED MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN, THEN, SUBJECT TO (4) BELOW, YOUR ATTORNEY IN FACT WOULD BE AUTHORIZED TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE.*)**;

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(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) TO YOU, UNLESS:

(A) YOU ARE IN A TERMINAL CONDITION OR IN A PERMANENTLY UNCONSCIOUS STATE.

(B) YOUR ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED YOU DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN.

(C) IF, BUT ONLY IF, YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE, YOU AUTHORIZE THE ATTORNEY IN FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU BY DOING BOTH OF THE FOLLOWING IN THIS DOCUMENT:

(I) INCLUDING A STATEMENT IN CAPITAL LETTERS OR OTHER CONSPICUOUS TYPE, INCLUDING, BUT NOT LIMITED TO, A DIFFERENT FONT, BIGGER TYPE, OR BOLDFACE TYPE, THAT THE ATTORNEY IN FACT MAY REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE AND IF THE DETERMINATION THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN IS MADE, OR CHECKING OR OTHERWISE MARKING A BOX OR LINE (IF ANY) THAT IS ADJACENT TO A SIMILAR STATEMENT ON THIS DOCUMENT;

(II) PLACING YOUR INITIALS OR SIGNATURE UNDERNEATH OR ADJACENT TO THE STATEMENT, CHECK, OR OTHER MARK PREVIOUSLY DESCRIBED.

(D) YOUR ATTENDING PHYSICIAN DETERMINES, IN GOOD FAITH, THAT YOU AUTHORIZED THE ATTORNEY IN FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE BY COMPLYING WITH THE REQUIREMENTS OF (4)(C)(I) AND (II) ABOVE.

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use;

(6) Provide, refuse, or withdraw informed consent to life-sustaining treatment, or the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, if the attorney in fact is subject to a temporary protection order, civil protection order, or any other protection order in this state or another state in which you are the alleged victim.

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact **GENERALLY*** will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the attorney in fact under this document. However, you **CANNOT*** designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you **CANNOT*** designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

Principal's initials: _____

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This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

Principal's initials: _____

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DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(Ohio Revised Code 1337.11 to 1337.17)

I,

Full legal name of principal | Date of birth

Address

designate the following person as my attorney in fact to make health care decisions for me whenever my attending physician determines that I have lost the capacity to make informed health care decisions for myself:

Name | Address | Telephone

If my attorney in fact is not available, willing, or able to act, I designate the following alternates, in this order:

First alternate | Address | Telephone

Second alternate | Address | Telephone

Authority. Subject to the limits of Ohio law described in the Notice and any limitations below, my attorney in fact has full authority to make health care decisions for me, to the same extent I could if I had capacity, including to give, refuse, or withdraw informed consent to any care, treatment, service, or procedure, to obtain and disclose my health care records and information as my personal representative under HIPAA, and to employ and discharge health care providers. My attorney in fact must act consistently with my desires or, if my desires are unknown, in my best interest.

Nutrition and hydration (initial only if you agree):

☐ **IF I AM IN A PERMANENTLY UNCONSCIOUS STATE, MY ATTORNEY IN FACT MAY REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED NUTRITION OR HYDRATION TO ME, IF MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINE THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN.**

Principal's initials: _____

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Limitations and wishes (optional):

Expiration (optional): this document expires on

Date (leave blank for no expiration)

Guardian. If a guardian of my person is to be appointed, I nominate my attorney in fact (or the first available alternate).

Prior documents. This document revokes any prior durable power of attorney for health care I created. A copy of this document is as valid as the original.

X _____
Signature of principal

Date

Sign in ONE of two ways: before **two adult witnesses** (below) **or** before a **notary** (next page). Witnesses may not be related to you by blood, marriage, or adoption, and may not be your attorney in fact, your attending physician, or the administrator of a nursing home where you receive care.

OPTION 1: WITNESSES. I attest that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and not under or subject to duress, fraud, or undue influence. I further attest that I am not the attorney in fact designated in this document, I am not the attending physician of the principal, I am not the administrator of a nursing home in which the principal is receiving care, and I am not related to the principal by blood, marriage, or adoption.

X _____
Witness signature

Printed name

Date

Address

X _____
Witness signature

Printed name

Date

Address

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OPTION 2: NOTARY ACKNOWLEDGMENT

STATE OF OHIO)
) **ss.**
COUNTY OF) _____

On the date below, before me, a notary public, personally appeared the principal named below, known to me or satisfactorily proven to be the person whose name is subscribed to this document, who acknowledged executing it and who appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

Name of principal

Date

X _____
Notary Public

(Notary seal)

Notary's printed name

My commission expires

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