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How to Complete Your Pennsylvania Health Care Power of Attorney

Durable Health Care Power of Attorney • 20 Pa.C.S. Chapter 54

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, and gives your agent access to your medical records. It does not cover money or property; for that, use a Durable General Power of Attorney.

1. **Choose when your agent may act**
   Usually only when your doctor finds you cannot decide for yourself. You may allow it sooner.
2. **Initial the powers you grant**
   Write your initials next to each power. A power you do not initial is not granted.
3. **Name your agent and alternates**
   Your doctor or health care provider cannot be your agent unless related to you.
4. **Add guidance (optional)**
   Describe your goals and values so your agent can follow them.
5. **Sign before two adult witnesses and a notary**
   Do not sign ahead of time. Bring a current photo ID.

Signing requirements: Two witnesses, age 18 or older, are required (20 Pa.C.S. § 5452). The person signing for you cannot be a witness. Notarizing it as well helps it be accepted in other states, at hospitals and by out-of-state family.

After It's Signed

- Give copies to your agent, your doctors, your hospital, and close family.
- Pair it with a Pennsylvania Living Will to state your end-of-life treatment wishes.

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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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DURABLE HEALTH CARE POWER OF ATTORNEY

Commonwealth of Pennsylvania • 20 Pa.C.S. Chapter 54, Subchapter C • Based on the example form in § 5471

Principal full name

County of residence

I, the principal named above, of the county named above, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.

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 thereunder 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.

WHEN MY AGENT MAY DECIDE (check one)

☐ 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 make decisions for me immediately, even while I am able to decide for myself; my own decisions control if we disagree.

My health care agent may not delegate the authority to make decisions.

POWERS OF MY HEALTH CARE AGENT

Subject to any health care treatment instructions I give, my health care agent has the powers I have **initialed** below. **A power that is not initialed is not granted.**

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.
7. To authorize or refuse to authorize donation of what we traditionally think of as organs (for example, heart, lung, liver, kidney), tissue, eyes or other parts of the body.
8. To authorize or refuse to authorize donation of hands, facial tissue, limbs or other vascularized composite allografts.

APPOINTMENT OF HEALTH CARE AGENT

Health care agent (name and relationship)

Phone

Address

E-mail

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If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named.

First alternative health care agent (name and relationship) | Phone

Address | E-mail

Second alternative health care agent (name and relationship) | Phone

Address | E-mail

IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES AND VALUES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT. NOTE THAT YOU MAY NOT APPOINT YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER AS YOUR HEALTH CARE AGENT UNLESS RELATED TO YOU BY BLOOD, MARRIAGE OR ADOPTION.

GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL)

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.):

Severe brain damage or brain disease. If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness.

☐ I agree

☐ I disagree

ADDITIONAL INSTRUCTIONS (optional)

You may also attach a Pennsylvania Living Will. Write any other instructions, limits, or religious preferences here:

LEGAL PROTECTION

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

SIGNATURE

Having carefully read this document, I have signed it on the date below, revoking all previous health care powers of attorney.

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X _____ Date

Principal signature (sign full name)

Witnesses

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness the principal's signature in each other's presence. A person who signs this document on behalf of and at the direction of the principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)

X _____ Date

Witness 1 signature

Witness 1 printed name

Witness 1 address

X _____ Date

Witness 2 signature

Witness 2 printed name

Witness 2 address

NOTARIZATION (RECOMMENDED)

A document that is both witnessed and notarized is more likely to be honored in other states.

ACKNOWLEDGMENT

COMMONWEALTH OF PENNSYLVANIA

COUNTY OF

This record was acknowledged before me on _____ (date) by _____ (name(s) of individual(s)).

X _____

Signature of notarial officer

Title of office (e.g., Notary Public)

My commission expires

Commission number

(Notary seal)

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