MEDICAL POWER OF ATTORNEY

1. 1. Designation of Principal and Health Care Agent

I, [PRINCIPAL FULL NAME], residing at [PRINCIPAL ADDRESS], date of birth [PRINCIPAL DATE OF BIRTH] (the "Principal"), appoint [AGENT FULL NAME], residing at [AGENT ADDRESS], home telephone [AGENT HOME PHONE], mobile telephone [AGENT MOBILE PHONE], relationship to me [RELATIONSHIP], as my health care agent (the "Agent") to make health care decisions for me as described in this Medical Power of Attorney (this "Document"). I intend this appointment to give my Agent the authority to make any health care decision I could make for myself if I had capacity, subject only to the limitations stated in Section 8 and to applicable law. I revoke any prior medical power of attorney, health care proxy, or health care agent designation I have signed, except [PRIOR DOCUMENT TO REMAIN IN EFFECT, if any].

2. 2. Successor Agents

If my Agent named above is unwilling, unable, unavailable, or not reasonably reachable when a decision is needed, or if my Agent is my spouse and an action for dissolution of marriage, annulment, or legal separation between us has been filed, I appoint [SUCCESSOR AGENT ONE FULL NAME], telephone [SUCCESSOR ONE PHONE], relationship [SUCCESSOR ONE RELATIONSHIP], to serve as my Agent. If that person is also unable or unwilling to serve, I appoint [SUCCESSOR AGENT TWO FULL NAME], telephone [SUCCESSOR TWO PHONE], relationship [SUCCESSOR TWO RELATIONSHIP]. Each successor has the full authority granted to my original Agent. Only one person may serve as my Agent at a time, and a health care provider may rely on the statement of a successor Agent that the prior Agent is unavailable or unwilling to serve. I direct that my Agent, and not any other family member, has priority to make decisions for me over any person who would otherwise be authorized by law.

3. 3. When the Authority of the Agent Begins

The authority of my Agent takes effect when my attending physician, and [SECOND OPINION ELECTION, e.g., a second physician / a physician and a licensed psychologist], determines in writing that I lack the capacity to understand and communicate health care decisions, and it continues for as long as that condition lasts. If I regain the capacity to make and communicate my own decisions, the authority of my Agent is suspended and I resume making my own health care decisions, whatever my Agent may have decided in the meantime. My own instruction always overrides that of my Agent while I have capacity, and a health care provider will follow my direct instruction even if I have previously signed this Document. This Document is durable and is not affected by my later incapacity or by the passage of time.

4. 4. Powers of the Health Care Agent

My Agent may: consent to, refuse, or withdraw consent to any medical care, treatment, service, procedure, test, medication, or surgery; select, engage, and discharge physicians, dentists, nurses, therapists, and other providers; admit me to and discharge me from a hospital, hospice, nursing facility, rehabilitation facility, assisted living residence, or other health care institution; consent to measures for comfort care and pain relief even if they may hasten death; authorize or refuse the administration of medication; arrange home health services and in-home care; consent to my transfer to another facility, provider, or geographic location; apply for and manage insurance benefits, Medicare, Medicaid, and other coverage relating to my care; sign consent forms, waivers, releases, and any document required to carry out a decision, including a document titled leaving against medical advice; and take any action necessary to obtain, examine, copy, and consent to the disclosure of my medical records. My Agent will make decisions consistent with the instructions in Section 5 and, where those instructions do not address the

situation, in accordance with what my Agent believes I would want, and where that is unknown, in my best interest.

5. 5. My Health Care Instructions and End-of-Life Wishes

I direct my Agent and my health care providers to follow these instructions. LIFE-SUSTAINING TREATMENT: If I have an incurable and irreversible condition that will result in my death within a relatively short time, if I become unconscious and it is determined to a reasonable degree of medical certainty that I will not regain consciousness, or if the likely risks and burdens of treatment would outweigh the expected benefits, I direct that [LIFE SUPPORT ELECTION, e.g., life-sustaining treatment be withheld or withdrawn and that I be permitted to die naturally / all available life-sustaining treatment be provided]. ARTIFICIAL NUTRITION AND HYDRATION: I direct that artificially administered nutrition and hydration [NUTRITION ELECTION, e.g., be withheld or withdrawn in the circumstances described above / be provided]. CARDIOPULMONARY RESUSCITATION: [CPR ELECTION, e.g., I direct that resuscitation be attempted / I do not want resuscitation attempted, and I understand that a separate physician order may be required for that direction to be followed by emergency responders]. COMFORT CARE: I want sufficient medication to relieve pain and discomfort even if it may hasten my death, and I want to be kept clean, warm, and treated with dignity. OTHER WISHES: [ADDITIONAL INSTRUCTIONS, e.g., preferences about dialysis, ventilator use, antibiotics, place of care, religious observances, and who I want present]. If I am pregnant, my wishes are: [PREGNANCY INSTRUCTION, if any], and I understand that state law may restrict how these instructions are applied during pregnancy.

6. 6. Mental Health Treatment

My Agent [MENTAL HEALTH ELECTION, e.g., MAY / MAY NOT] make decisions regarding my mental health treatment, including consenting to or refusing treatment by a psychiatrist or psychologist, consenting to or refusing psychotropic medication, and consenting to admission to a facility for mental health care on a voluntary basis. My preferences regarding mental health treatment are: [MENTAL HEALTH PREFERENCES, e.g., preferred medications and those to avoid, preferred facilities, providers to contact]. I understand that involuntary commitment, electroconvulsive therapy, and certain other interventions are governed by separate state procedures and may require a court order or a specific declaration that this Document does not by itself supply. My Agent will notify [MENTAL HEALTH CONTACT] if I am admitted for mental health care.

7. 7. HIPAA Authorization and Access to Records

I intend for my Agent to be treated as my personal representative under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, and I authorize any physician, hospital, clinic, laboratory, pharmacy, insurer, health plan, or other covered entity to disclose to my Agent all of my protected health information, including medical records, test results, imaging, billing records, and information about mental health treatment, substance use treatment, and communicable diseases, to the extent permitted by law. This authorization applies whether or not I currently lack capacity and continues until I revoke it in writing. My Agent may request, receive, examine, copy, and consent to further disclosure of that information, and may discuss my care with any provider. A copy of this Document has the same effect as the original for the purposes of this authorization. I also authorize disclosure of my health information to [ADDITIONAL AUTHORIZED PERSONS, e.g., named family members], and I direct that my health information not be disclosed to [PERSONS EXCLUDED, if any].

8. 8. Limitations on the Authority of the Agent

My Agent may not: make decisions about my property, finances, or business affairs, which are addressed in a separate financial power of attorney; consent to any treatment or action I have expressly refused in Section 5;

consent to an act that is contrary to my known religious or moral beliefs as stated here: [RELIGIOUS OR MORAL BELIEFS, if any]; or take any action prohibited by applicable law. My Agent may not consent on my behalf to [SPECIFIC EXCLUSIONS, e.g., psychosurgery, sterilization, experimental treatment not approved for my condition, or participation in medical research], except as follows: [RESEARCH ELECTION, if any]. My Agent must give effect to my known wishes and may not substitute a personal preference for mine. If my Agent is unwilling to follow an instruction in Section 5, my Agent will inform my attending physician promptly and will step aside in favor of my successor Agent.

9. 9. Organ Donation and Disposition of Remains

ANATOMICAL GIFT: On my death, I [DONATION ELECTION, e.g., DO / DO NOT] wish to make an anatomical gift. If I do, I give [DONATION SCOPE, e.g., any needed organs and tissues / only the following organs and tissues: [SPECIFIED ORGANS]] for the purpose of [DONATION PURPOSE, e.g., transplantation, therapy, research, or education]. My Agent [DONATION AUTHORITY ELECTION, e.g., MAY / MAY NOT] make or decline an anatomical gift on my behalf consistent with this direction. AUTOPSY: I [AUTOPSY ELECTION, e.g., consent to / do not consent to] an autopsy unless one is required by law. DISPOSITION OF REMAINS: I direct that my remains be [DISPOSITION ELECTION, e.g., buried / cremated] and that arrangements be handled by [PERSON RESPONSIBLE FOR ARRANGEMENTS], with these additional wishes: [FUNERAL AND MEMORIAL WISHES]. I understand that the authority to direct the disposition of remains is governed by state law and that a separate designation may be required in my state.

10. 10. Nomination of Guardian and Provider Reliance

If a court determines that a guardian, conservator, or similar fiduciary of my person should be appointed, I nominate my Agent named in Section 1, and then my successor Agents in the order listed, to serve in that role. I ask the court to give effect to this nomination and to the decisions my Agent has made under this Document. Any health care provider, facility, insurer, or other person may rely on this Document and on the decisions of my Agent without further inquiry and without liability, unless that person has actual knowledge that this Document has been revoked. A photocopy, facsimile, or electronic copy of this signed Document has the same force and effect as the original. I release and hold harmless any provider who follows the direction of my Agent in good faith, to the extent permitted by law. If a provider or facility declines on grounds of conscience to follow an instruction in this Document, I direct that I be transferred promptly to a provider who will follow it.

11. 11. Revocation and Effect on Other Documents

I may revoke this Document at any time and by any means that communicates my intent to revoke, including signing a written revocation, destroying the original, telling my physician or my Agent, or signing a later medical power of attorney. Revocation is effective as to a health care provider when the provider is notified, and I ask that my Agent and my physician be informed promptly of any revocation. The appointment of my spouse as Agent is revoked automatically on the filing of an action for dissolution of marriage, annulment, or legal separation, unless I state otherwise here: [SPOUSE ELECTION, if any]. This Document [PRIOR DIRECTIVE ELECTION, e.g., supersedes / is intended to be read together with] any living will, advance directive, or physician order for life-sustaining treatment I have signed, and if there is a conflict, the more recently signed document controls. I will give copies of this Document to my Agent, my successor Agents, my primary care physician, and [OTHER RECIPIENTS], and will keep the original at [DOCUMENT LOCATION].

12. 12. Signature, Witnesses, and Notarization

I sign this Medical Power of Attorney willingly, understand its contents, and am of sound mind and under no duress or undue influence. PRINCIPAL: [PRINCIPAL FULL NAME]. Signature: _____.

Date: [DATE]. WITNESS STATEMENT: Each witness affirms that the Principal signed this Document in the presence of the witness, appeared to be of sound mind and free from duress, and that the witness is at least eighteen years old, is not the Agent or a successor Agent, is not related to the Principal by blood, marriage, or adoption, is not entitled to any part of the estate of the Principal, and is not the attending physician or an employee of a facility where the Principal is a patient. WITNESS ONE: Signature: _____. Printed Name: [WITNESS ONE NAME]. Address: [WITNESS ONE ADDRESS]. Date: [DATE]. WITNESS TWO: Signature: _____. Printed Name: [WITNESS TWO NAME]. Address: [WITNESS TWO ADDRESS]. Date: [DATE]. State of [STATE], County of [COUNTY]. On [NOTARY DATE], before me personally appeared [PRINCIPAL FULL NAME], known to me or satisfactorily identified, who acknowledged executing this instrument as a free and voluntary act. Notary Public: _____. My commission expires: [EXPIRATION DATE]. AGENT ACKNOWLEDGMENT: [AGENT FULL NAME]. Signature: _____. Date: [DATE].

13. Disclaimer

This template is provided for general informational purposes only and is not legal advice. Medical powers of attorney are governed by state law, and the requirements for witnesses, notarization, who may serve as agent, the wording that triggers authority, and instructions relating to resuscitation or pregnancy differ significantly from state to state. Many states publish an official advance directive form that hospitals recognize immediately, and a do-not-resuscitate direction usually requires a separate physician order to be honored by emergency responders. Have this document reviewed by a licensed attorney in your state, give copies to your agent and your physician, and confirm that your hospital has it on file. Use of this template does not create an attorney-client relationship with ScanContract.