COLORADO ADVANCE DIRECTIVES

Being of sound mind, I appoint these Agents and make this Declaration in consideration of a future time when I may not be able to participate in a necessary medical decision. This document supersedes all previous Advance Directives signed by me.

This document shall be governed by the laws of the State of Colorado in all respects, including its validity, construction, interpretation, and termination. However, I intend for this document to be honored in any jurisdiction in which it may be presented and for any such jurisdiction to refer to Colorado law to interpret and determine the validity of this document and any of the powers granted under this document.

Photocopies of this document shall be as effective as the original. I specifically direct my Agent to have photocopies of this document placed in my medical records.

PART ONE. MEDICAL DURABLE POWER OF ATTORNEY

I, ____,
Print name

of ____,
Address

hereby appoint, to serve as my Agent and to exercise the powers set forth below:

____
Print name, address, phone and email

____

If my Agent is not available, or unable or unwilling to serve, I hereby designate as my First Alternate Agent:

____
Print name, address, phone and email

____

If my First Alternate Agent is not available, or unable or unwilling to serve, I designate as my Second Alternate Agent:

____
Print name, address, phone and email

____

ACTIVE DATE AND DURABILITY

This Medical Durable Power of Attorney shall be effective upon, and only during, any period of disability or incapacity in which, in the opinion of my attending healthcare professional, I am unable to make or communicate responsible decisions regarding medical treatment or healthcare for myself.

AGENT POWERS

I grant to my Agent full authority to make decisions for me regarding medical and psychological treatment. In exercising this authority, my Agent shall follow my desires as stated in my Declaration as to Medical or Surgical treatment. In making decisions, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate rationally.

If my Agent cannot determine the choice I would want made, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interest. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below. Accordingly, my Agent is authorized as follows:

1. To consent to, refuse, or withdraw consent to, any and all types of medical and psychiatric care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect bodily function, including (but not limited to) artificial respiration, artificial nourishment and hydration, and cardiopulmonary resuscitation.

2. To take any other action necessary to implement my preferences as expressed herein or elsewhere, including (but not limited to) granting any waiver or release from liability required by any hospital, healthcare professional, or other healthcare provider; signing any documents relating to acceptance or refusal of treatment or discharge from a facility against medical advice; and pursuing any legal action in my name and at my own or my estate's expense to enforce compliance with my wishes as determined by my Agent, including claims for actual or punitive damages for any such failure to comply.

3. To have access to my medical records and information to the same extent that I am entitled, including the right to disclose the contents to others as appropriate.

4. To authorize my admission to or discharge from any hospital, long term care facility, assisted living, or similar care facility or service.

5. To contract on my behalf for any healthcare related service or facility, without my Agent's incurring personal financial liability for such contracts. To retain and discharge medical, hospice, social service and other support personnel responsible for my care.

6. To make anatomical gifts upon my death as follows. *(Initial those that apply)*

_____ Organ donations for the limited purpose of transplantation to such persons or organizations as my agent shall deem appropriate, and to execute such papers and do such acts as shall be necessary and appropriate with such gifts.

______ Tissue gifts for the limited purpose of transplantation to such persons and organizations as my agent shall deem appropriate, and to execute such papers and do such acts as shall be necessary and appropriate with such gifts.

______ Anatomical gifts for the purpose of medical research to such persons and organizations as my agent shall deem appropriate, and to execute such papers and do such acts as shall be necessary and appropriate in connection with such gifts.

_______I do not authorize my agent to make any anatomical gifts on my behalf.

ACCESS TO MY MEDICAL RECORDS AND OTHER PERSONAL INFORMATION

My Agent shall have the power to request, receive, review and release any information, including drug-and-alcohol treatment information, mental health information, medical and hospital records and other data having special protections under the law, specifically including the Health Insurance Portability and Authorization Act of 1996 (HIPAA), regarding my physical or mental health; and to execute any releases, waivers, insurance forms, or other documents that may be requested in order to obtain such information; or to obtain government assistance or insurance payment for any service rendered to me or for my benefit. Each person nominated to be my Agent shall specifically be authorized to receive all personal health information and documents necessary to determine my incapacity as if such persons were already acting as my Agent.

GRANTING RELEASES

My Agent, on behalf of me, my heirs, and my estate, shall have the power to grant waivers or releases from liability to healthcare providers and other persons or covered entities (as defined under HIPAA) involved in providing healthcare services for me or maintaining my protected health information and other healthcare records, who act in reliance on instructions given by my Agent for the purpose of carrying out the provisions of this document.

PART TWO. DECLARATION AS TO MEDICAL OR SURGICAL TREATMENT (LIVING WILL)

1. If I have an terminal injury, illness or disease; am in a prolonged, and/or irreversible comatose or persistent vegetative state; or am in an advanced stage of progressive dementia in which I am unable to coherently communicate, swallow food and water safely, care for myself, or recognize my family and other people; and if two healthcare professionals certify in writing that there is no reasonable probability of recovery from these conditions, I direct that the procedures I have indicated be initiated and continued (check Yes), or withheld and withdrawn (check No). *I am aware that withholding or withdrawing any of these procedures may hasten my death.*

	Yes	Trial*	No
Surgery, unless it is necessary to control pain			
Antibiotics			
Pneumonia vaccine			
Cortisone or other steroid therapy			
Heart-regulating drugs, including electrolyte replacement, if my heartbeat becomes irregular			
Cardiopulmonary resuscitation including electronic shock in the event of cardiac arrest			
Pacemaker to regulate my heartbeat			
Stimulants, diuretics or any other treatment for heart failure			
Invasive diagnostic tests			
Intubation (insertion of a tube to admit air or administer gases)			
Respirator support (breathing by machine)			
Blood, plasma or replacement fluids			
Kidney dialysis			
Cortisone or other steroid therapy			
Other life prolonging therapies or medications as noted:			

*A trial period means that doctors will see if a therapy quickly reverses my condition. If it does not, I want it discontinued.

Life-sustaining procedures include, but are not limited to, the above.

2. Specifically in regard to NOURISHMENT AND HYDRATION, I have checked the following items with which I agree:

If I am conscious, but incompetent, and unable or unwilling to eat or to be fed in the usual manner, I declare my wish to:

______ voluntarily stop eating and drinking by mouth

______refuse intravenous feeding for nutrition and/or hydration

______refuse tube feeding for nutrition and/or hydration

If I am unconscious and my healthcare providers have established that there is no reasonable likelihood that I will ever return to a conscious state (such as the condition sometimes called the Permanent or Persistent Vegetative State), I declare my wish to:

______refuse intravenous feeding for nutrition and/or hydration

______refuse tube feeding for nutrition and/or hydration

EXCULPATION

A. My Agent and my Agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, heirs, successors, and assigns from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my Agent. No person who relies in good faith upon any representations by my Agent or Alternate Agents shall be liable to me, my estate, my heirs or my successors or assigns for recognizing the Agent's authority.

B. Any healthcare professional or other individual acting on my behalf is authorized and directed to follow these instructions. No healthcare professional signing a certificate of terminal condition and no healthcare professional, hospital or hospital personnel withholding or withdrawing life-sustaining procedures in compliance with this declaration, in the absence of actual knowledge of revocation or fraud, misrepresentation, or improper execution, shall be subject to civil liability, criminal penalty, or licensing sanctions therefore. On behalf of myself, my Agents, my family and my heirs and devisees, I hereby release any person who acts in reliance on the foregoing sentence from any claim or liability for any injury to me or arising by reason of my death.

NOMINATION OF GUARDIAN

If a guardian should need to be appointed, I nominate my Agent (or Alternate Agent) named above.

REVOCATION AND RESIGNATION

I reserve the right to revoke or amend this document and to substitute other Agents in place of those designated herein while I am mentally competent. Amendments or revocation shall only be made in writing by me personally, and shall be attached to or replace the original of this document.

My agent and any Alternate Agent may resign by the execution of a written resignation delivered to me or, if I am mentally incapacitated, by delivery to any person in charge of my care and custody.

SEVERABLITY

If any part of any provision of this document shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity only, without in any way affecting the remaining provisions of this document.

SIGNATURES

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT. I AM OF SOUND MIND AND WILLFULLY AND VOLUNTARILY EXECUTE THIS DOCUMENT.

I sign my name to this Medical Durable Power of Attorney and Declaration as to Medical or Surgical Treatment on this ______ day of _____________, 20________

Signature ____

Home address ____

WITNESSES' STATEMENT

I do hereby declare that the Principal (the person who has signed or acknowledged this document), ______________________________, has signed or acknowledged this Medical Durable Power of Attorney and Declaration as to Medical / Surgical Treatment Document in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

To the best of my knowledge, I am not a creditor of the Principal nor entitled to any part of his or her estate under a will now existing or by operation of law.

Witness No. 1

Signature: ___________________________________Date: _____________________

____
Print name, address, phone and email

____

Witness No. 2

Signature: ___________________________________Date: _____________________

____
Print name, address, phone and email

____

ACCEPTANCE OF APPOINTMENT BY AGENTS

The undersigned accept appointment as Agent and Alternate Agents under this Medical Durable Power of Attorney and Directive for Medical or Surgical Treatment.

____

Print Agent's name, address, phone and email

____

Signature: ____________________________________Date: ______________________

____

Print 1st Alternate Agent's name, address, phone and email

____

Signature: ____________________________________Date: ______________________

____

(Optional) Print 2nd Alternate Agent's name, address, phone and email

____

Signature: ____________________________________Date: ______________________

Notarizing is optional. If you wish to have this document notarized, use the following form:

STATE OF COLORADO
CITY _______________________________ COUNTY ___________________________

Subscribed and sworn to before me by _______________________________________,

(the Principal), and ____ and

____, as witnesses, as a voluntary act of

the Principal, this _____ day of____________, 20___.

Notary Public _________________________________ My commission expires:_______

Address of Notary Public: ____