Durable Power of Attorney for Health Care(Patient Advocate)

If I am no longer able to make my own health care decision, this form names the person I choose to make these decisions for me. This person will be my Patient Advocate. My Patient Advocate is:

Name _____

Address _____

City/State/Zip _____

Phone Number _____

If this person is not able, available, or willing to make these decisions for me, then my next choice to serve as my Patient Advocate is:

Name _____

Address _____

City/State/Zip _____

Phone Number _____

Appointment of Patient Advocate

I understand that my advocate shall have the authority to make all decisions and to take all actions regarding my care, custody and medical treatment even if the decision may result in my death. I have discussed this document with my physician and understand the consequences of my decisions.

Patient Signature _____

Printed Name _____

Address _____

City/State/Zip _____

Phone _____

Date _____

Witnesses (2 witnesses required)

Witness 1

Witness Signature _____

Printed Name _____

Address _____

City/State/Zip _____

Phone _____

Date _____

Witness 2

Witness Signature _____

Printed Name _____

Address _____

City/State/Zip _____

Phone _____

Date _____