INTEGRIS HEALTH

Health Care Power of Attorney

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

This form is a power of attorney for health care that lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term health care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

1. Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
2. Select or discharge health care providers and facilities; and
3. Sign a do-not-resuscitate consent.

This form does not authorize the agent to make any decisions directing the withholding or withdrawal of life-sustaining treatment, nutrition, or hydration, which may only be authorized in compliance with the Oklahoma Advance Directive Act, except that this form may authorize the agent to sign a do-not-resuscitate consent.

After completing this form, sign and date the form at the end. It is required that two other individuals sign as witnesses. These witnesses must be at least 18 years old and not related to you or named to inherit from you. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care facility at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility. You have the right to revoke this power of attorney for health care or replace this form at any time.

POWER OF ATTORNEY FOR HEALTH CARE

1. DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____

Name of individual you choose as agent

_____

Address City State Zip code

_____

Home phone Work phone

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____

Name of individual you choose as first alternate agent

_____

Address City State Zip code

_____

Home phone Work phone

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____

Name of individual you choose as second alternate agent

_____

Address City State Zip code

Patient Label
Patient Name:
MRN:
DOB:

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Home phone Work phone

2. **AGENT'S AUTHORITY:** My agent is authorized to make all health care decisions (not to include the withholding or withdrawal of life-sustaining treatment, nutrition, or hydration, other than signing a do-not-resuscitate consent) for me that I could make if I were able, except as I state here:

Add additional sheets if needed

3. **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE**: My agent's authority becomes effective when my attending physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

_____
(Initials)

4. **AGENT'S OBLIGATION:** My agent shall make health care decisions for me in accordance with this power of attorney for health care and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider the decisions I would have made myself to the extent known to my agent.

_____
(Initials)

5. **RELIEF FROM PAIN**: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

Add additional sheets if needed

6. **OTHER WISHES:** (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions, you have given above, you may do so here.) I direct that:

Add additional sheets if needed

7. **EFFECT OF COPY**: A copy of this form has the same effect as the original.
8. **SIGNATURES**: Sign and date the form here:

Sign your name Date Time

Print your name

Address City State Zip Code

SIGNATURES OF WITNESSES:

First witness

Print name

Address City State Zip

Signature of witness

Date Time

Second witness

Print name

Address City State Zip

Signature of witness

Date Time

Patient Label
Patient Name:
MRN:
DOB:

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