**MEDICAL POWER OF ATTORNEY**

**State: Rhode Island**

**Information About the Principal**

Principal’s Full Name: [NAME]

Principal’s Address: [ADDRESS]

Principal’s Phone: [NUMBER]

Principals DOB: [DOB]

Principal’s Email Address: [EMAIL]

**Health Care Agent**

Agent’s Full Name: [NAME]

Agent’s Address: [ADDRESS]

Agent’s Phone: [NUMBER]

Agent’s DOB: [DOB]

Agent’s Email Address: [EMAIL]

**Back-up Agents**

Back-up Agent’s Full Name: [NAME]

Back-up Agent’s Address: [ADDRESS]

Back-up Agent’s Phone: [NUMBER]

Back-up Agent’s DOB: [DOB]

Back-up Agent’s Email Address: [EMAIL]

If the first two agents are not willing or able to act for any reason, then my next choice is:

**Second Back-up Agents**

Second Back-up Agent’s Full Name: [NAME]

Second Back-up Agent’s Address: [ADDRESS]

Second Back-up Agent’s Phone: [NUMBER]

Second Back-up Agent’s DOB: [DOB]

Second Back-up Agent’s Email Address: [EMAIL]

**Agent’s Powers**

1. My agent knows my goals and wishes based on our conversations and on any other guidance I may have written. If I am able to communicate in any manner, my agent should discuss my health care options with me. If I am incapacitated, my agent has full authority to make decisions for me about my health care according to my wishes. If the choice I would make is unclear, then my agent will decide based on what they believe to be in my best interests. My agent’s authority to interpret my wishes is intended to be as broad as possible, and includes the following authority: [INSERT THOSE THAT APPLY]

[To agree to, refuse, or withdraw consent to any type of medical care, treatment, surgical procedures, tests, or medications. This includes decisions about using mechanical or other procedures that affect any bodily function, such as artificial respiration, artificially supplied nutrition and hydration for example, tube feeding, cardiopulmonary resuscitation, or other forms of medical support, even if deciding to stop or withhold treatment could or would result in my death.]

[To authorize my admission to or discharge (against medical advice, if necessary) from any hospital, nursing home, residential care, assisted-living or similar facility or service.]

[To hire and fire medical, social service, and other support personnel who are responsible for my care.]

[To contract for any health care-related service or facility for me or apply for public or private health care benefits. My agent is not personally financially responsible for those contracts.]

[To authorize my participation in medical research related to my medical condition.]

[To agree to or refuse using any medication or procedure aimed to relieve pain or discomfort, even though that use may lead to physical damage or dependence or hasten my death.]

[To take any other action necessary to do what I authorize here, including signing waivers or other documents, pursuing any dispute resolution process, or taking legal action in my name.]

1. [INSERT IF APPLICABLE] Unless there is a court order to the contrary, a health care decision of an agent shall take precedent over that of any guardian.
2. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

**HIPPA Authorization**

1. When considering or making health care decisions for me, all individually identifiable health information and medical records shall be released without restriction to my health care agent(s), and/or my alternative health care agent(s) named above including, but not limited to, diagnostic, treatment, other health care, and related insurance and financial records, and information associated with any past, present, or future physical or mental health condition including, diagnosis or treatment f HIV/AIDS, sexually transmitted disease(s) mental illness, and/or drug or alcohol abuse, and any written opinion relating to my health that such head care agent(s) and/or alternative healthcare agent(s) may have requested. Without limiting the generalist of the foregoing, this release authority applies to all health information and medical records governed by the Health Information Portability and Accountability Act of 1996 (HIPPA) 42 USC 1320d and 45 CFR 160-164; is effective whether or not I am mentally competent; has no expiration date; and shall terminate only in the event that I revoke the authority in writing and deliver it to my health care provider.

**Pregnancy** [INSERT IF APPLICABLE]

1. If I have been diagnosed as pregnancy and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

**Authorization to Release Medical Information** [INSERT IF APPLICABLE]

1. Effective:
	1. [Immediately notwithstanding the provisions above] **OR**
	2. [when my agent’s authority becomes effective under the provisions of the above]

And continuously until my death or revocation by a writing signed by me or someone authorized to make health-care decisions for me. I authorize and request any health-care providers to give my agent access to medical records and information to the same extent that I am entitled to, along with the right to disclose health information to others.

**Spouse as an Agent** [INSERT IF APPLICABLE]

1. Upon divorce, or legal separation, my former spouse shall be automatically revoked from being my health care agent.

**Organ Donation**

1. I don’t want to donate my organs, tissue, or any part. **OR**
2. [INSERT IF YOU WANT TO DONATE ORGANS/TISSUE] I hereby give my agent permission to decide about organ and tissue donations, autopsy, and the disposition of my remains as the law permits.
3. The following organs I choose to donate: [INSERT ONE]
	1. [Whole body];
	2. [Any needed parts or organs];
	3. These parts or organs only:
		1. [INSERT INFORMATION]
4. What purposes I choose to donate organs/tissues for: [INSERT ONE]
	1. [**Any** legally authorized purpose (transplantation, therapy, medical and dental evaluation, education or research, and/pr advancement of medical and dental science)]
	2. [Transplant or therapeutic purposes only.]
	3. [Research only].
	4. [OTHER].

**Religious and Spiritual Requests** [INSERT IF APPLICABLE]

1. I want the following to be contacted if I become sick.

Name of Rabbi, Clergy, Minister, Imam, Monk or another spiritual advisor:

Address:

Phone Number:

**Special Instructions**

1. [INSERT SPECIAL INSTRUCTIONS]

**Primary Physician** (OPTIONAL)

1. I designate the following physician as my primary physician:
	1. [NAME];
	2. [ADDRESS];
	3. [PHONE NUMBER].
2. If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
	1. [NAME];
	2. [ADDRESS];
	3. [PHONE NUMBER].

**Revoking or Amending this Designation**

1. I understand that I may, at any time, revoke or amend this designation by:
	1. Signing a written and dated instrument which expresses my intent to amend or revoke this designation; or
	2. Physically destroying this designation through my own action or by that of another person in my presence and under my direction; or
	3. Verbally expressing my intention to amend or revoke this designation; or
	4. Signing a new designation that is materially different from this designation.
2. If the agent or an alternate agent designated is my spouse, and our marriage is thereafter dissolved, such designation shall be thereupon revoked.

**Effective Date**

1. This Power of Attorney will become effective during any time in which, in the opinion of my agent and attending physician, I am unable to make or communicate a choice about a particular health care decision.

**Other Provisions**

1. Health care providers can rely on my agent**.**
2. No one who relies in good faith on any representations by my agent or back-up agent will be liable to me, my estate, my heirs, or assigns, for recognizing the agent's authority.
3. I cancel any previous power of attorney for health care that I may have signed.
4. I intend this power of attorney to be universal; it is valid in any jurisdiction in which it is presented.
5. My agent will not be entitled to compensation for services performed under this power of attorney, but he or she will be entitled to reimbursement for all reasonable expenses that result from carrying out any provision of this power of attorney.
6. I intend that copies of this document are as effective as the original.
7. My agent shall not be:
	1. My treating health care provider;
	2. A non-relative employee of your treating health care provider;
	3. An operator of a community care facility; or
	4. A non-relative employee of an operator of a community care facility.

**SIGNATURE**

I understand the contents of this document and the effect of granting powers to my agent.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| **Principal's** Signature |  |  |

|  |  |  |
| --- | --- | --- |
|   |  |  |
| **Principal's** Name |  |  |

|  |  |  |
| --- | --- | --- |
|   |  |  |
| Date |  |  |

**A Statement by Your Witnesses**

I declare that I personally know you, the person who signed this document, or I have adequate proof of your identity, and that you signed or acknowledged this Power of Attorneyin front of me, and that you appear to be of sound mind and under no duress, fraud, or undue influence.

I am an adult and am not any of the following:

1. Appointed as your agent or back-up agent.
2. Under 19 years of age.
3. Related to you by blood, marriage, domestic partnership, or adoption, nor a spouse of any such person.
4. An employee of your health care provider.
5. Your health care provider, including the owner or operator of a health, long-term care, or other residential or community care facility serving you.
6. A creditor of yours or entitled to any part of your estate under a will or codicil, trust, insurance policy, or by operation of intestate succession laws.
7. Entitled to benefit financially in any other way after you die.
8. Cannot have a claim (actual or potential) against your estate.
9. Financially responsible for your health care.
10. An employee of your life or health insurance provider.

**SIGNATURE**

**First Witness**

|  |  |
| --- | --- |
|  |  |
| **Witness**Signature | Date |
|  |
| **Witness Name** |
|  |
| **Witness Address** |
|  |  |  |
| City | State | Zip Code |

**Second Witness**

|  |  |
| --- | --- |
|  |  |
| **Witness**Signature | Date |
|  |
| **Witness**Name |
|  |
| **Witness Address** |
|  |  |  |
| City | State | Zip Code |

**NOTARY ACKNOWLEDGEMENT OF PRINCIPAL**

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      )

                                                            )         **(Seal)**

County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   )

The foregoing instrument was acknowledged before me this [DATE] by the undersigned witnesses, [NAME], and [NAME], who are personally known to me or satisfactorily proven to me to be the person whose name is subscribed to the within instrument.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTARY ACKNOWLEDGEMENT OF WITNESSES**

**State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     )**

**)         (Seal)**

**County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   )**

The foregoing instrument was acknowledged before me this [DATE] by the undersigned witnesses, [NAME], and [NAME], who are personally known to me or satisfactorily proven to me to be the person whose name is subscribed to the within instrument.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Notary Public**

**My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**