STATE OF ARKANSAS)
) **DURABLE POWER OF**
) **ATTORNEY FOR HEALTH CARE**
COUNTY OF County Name)

I, Full Name, a resident of the State of Arkansas, being of sound mind and having reached the age of eighteen (18) years, do hereby make, publish and declare the following:

Durable Power of Attorney for Health Care Decisions. During any period in which I am incapacitated, in the opinion of my attending physician, or am unable to make or communicate a choice regarding a particular health care decision, I hereby delegate health care decision-making powers to Full Name of Agent, whose phone number is Agent's Telephone Numbe, as my agent, to make decisions relating to any care, treatment, service, or procedure to maintain, diagnose, treat or provide for my physical or mental health or personal care. Pursuant to the foregoing, and to the extent allowed by law (including Ark. Code Ann. § 20-6-101 *et seq*.), my aforementioned agent shall be authorized as follows:

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

(b) To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;

(c) To authorize my admission to or discharge, even against medical advice, from any hospital, nursing home, residential care, assisted living or similar facility or other healthcare facility;

(d) To contract on my behalf for any health care related service or facility on my behalf, without my agent incurring personal financial liability for such contracts;

(e) To select and discharge medical, social service, and other support personnel responsible for my care;

(f) To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death;

(g) To take any other action necessary to do what I authorize here, including but not limited to granting any waiver or release from liability required by any hospital, physician, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice; and pursuing any legal action

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in my name, and at the expense of my estate, to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply; and

(h) In addition to the foregoing:

(1) This power of attorney for healthcare is intended to be durable and shall not be affected by my subsequent disability or incapacity; and

(2) In the event that the person I have named above as my agent is unable or unwilling to serve as my agent for health care purposes contemplated hereunder, then Full Name of Secondary Agent, whose phone number is 2nd Agent's Telephone Numbe, able and willing to serve in such capacity, shall serve as my agent for health care purposes hereunder with all the powers granted herein.

(3) I hereby authorize all healthcare providers to disclose my physical or mental condition to the person(s) named herein as my agent. This authorization is intended to comply with the requirements of the Health insurance Portability and Accountability Act of 1996 (HIPAA), HIPAA regulations, and other State and Federal laws and regulations that may create a right of privacy in the health information approved to be disclosed by this authorization.

This document hereby revokes and supersedes any prior power of attorney for health care decisions.

DATED this Date day of Month, 20Yea

Signature: _____

Full Name: Full Name

Address: Address Line 1

Address Line 2

Phone Number: Telephone Number

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ACKNOWLEDGMENT

STATE OF ARKANSAS)
)
COUNTY OF County Name)

On this Date day of Month, 20 Yea, before me, the undersigned officer, personally appeared Full Name, known to me (or satisfactorily proven) to be the person who subscribed to the within instrument and acknowledged that he/she executed the same for the consideration, use and purposes therein contained.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this Dat day of Month, 20 Yea.

NOTARY PUBLIC

My Commission Expires:

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