NOTICE TO THE INDIVIDUAL SIGNING THE POWER OF ATTORNEY FOR HEALTH CARE

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your "health care agent". Your agent is the person you trust to make health care decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an "advance directive". You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and on-line resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

WHAT ARE THE THINGS I WANT MY HEALTH CARE AGENT TO KNOW

The selection of your agent should be considered carefully, as your agent will have the ultimate decision making authority once this document goes into effect, in most instances after you are no longer able to make your own decisions. While the goal is for your agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your agent to make decisions to direct or refuse health care interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

i. What is most important to you in your life?
ii. How important is it to you to avoid pain and suffering?
iii. If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?
iv. Would you rather be at home or in a hospital for the last days or weeks of your life?
v. Do you have religious, spiritual, or cultural beliefs that you want your agent and others to consider?
vi. Do you wish to make a significant contribution to medical science after your death through organ or whole body donation?
vii. Do you have an existing advanced directive, such as a living will, that contains your specific wishes about health care that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.

WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

If there is ever a period of time when your physician determines that you cannot make your own health care decisions, or if you do not want to make your own decisions, some of the decisions your agent could make are to:

i. Talk with physicians and other health care providers about your condition.
ii. See medical records and approve who else can see them.
iii. Give permission for medical tests, medicines, surgery, or other treatments.
iv. Choose where you receive care and which physicians and others provide it.
v. Decide to accept, withdraw, or decline treatments designed to keep you alive if you are near death or not likely to recover. You may choose to include guidelines and/or restrictions to your agent's authority.
vi. Agree or decline to donate your organs or your whole body if you have not already made this decision yourself. This could include donation for transplant, research, and/or education. You should let your agent know whether you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State or whether you have agreed to donate your whole body for medical research and/or education.
vii. Decide what to do with your remains after you have died, if you have not already made plans.
viii. Talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones).

Your agent is not automatically responsible for your health care expenses.

WHOM SHOULD I CHOOSE TO BE MY HEALTH CARE AGENT?

You can pick a family member, but you do not have to. Your agent will have the responsibility to make medical treatment decisions, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend, or other person who:

i. Is at least 18 years old;
ii. Knows you well;
iii. You trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;
iv. Would be comfortable talking with and questioning your physicians and other health care providers;
v. Would not be too upset to carry out your wishes if you became very sick; and
vi. Can be there for you when you need it and is willing to accept this important role.

WHAT IF MY AGENT IS NOT AVAILABLE OR IS UNWILLING TO MAKE DECISIONS FOR ME?

If the person who is your first choice is unable to carry out this role, then the second agent you chose will make the decisions; if your second agent is not available, then the third agent you chose will make the decisions. The second and third agents are called your successor agents and they function as back-up agents to your first choice agent and may act only one at a time and in the order you list them.

WHAT WILL HAPPEN IF I DO NOT CHOOSE A HEALTH CARE AGENT?

If you become unable to make your own health care decisions and have not named an agent in writing, your physician and other health care providers will ask a family member, friend, or guardian to make decisions for you. In Illinois, a law directs which of these individuals will be consulted. In that law, each of these individuals is called a "surrogate".

There are reasons why you may want to name an agent rather than rely on a surrogate:

i. The person or people listed by this law may not be who you would want to make decisions for you.
ii. Some family members or friends might not be able or willing to make decisions as you would want them to.
iii. Family members and friends may disagree with one another about the best decisions.
iv. Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

WHAT IF THERE IS NO ONE AVAILABLE WHOM I TRUST TO BE MY AGENT?

In this situation, it is especially important to talk to your physician and other health care providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes. You can complete a living will. You can also write your wishes down and/or discuss them with your physician or other health care provider and ask him or her to write it down in your chart. You might also want to use written or online resources to guide you through this process.

WHAT DO I DO WITH THIS FORM ONCE I COMPLETE IT?

Follow these instructions after you have completed the form:

i. Sign the form in front of a witness. See the form for a list of who can and cannot witness it.
ii. Ask the witness to sign it, too.
iii. There is no need to have the form notarized.

iv. Give a copy to your agent and to each of your successor agents.
v. Give another copy to your physician.
vi. Take a copy with you when you go to the hospital.
vii. Show it to your family and friends and others who care for you.

WHAT IF I CHANGE MY MIND?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one, including, but not limited to, your agents and your physicians.

WHAT IF I DO NOT WANT TO USE THIS FORM?

In the event you do not want to use the Illinois statutory form provided here, any document you complete must be executed by you, designate an agent who is over 18 years of age and not prohibited from serving as your agent, and state the agent's powers, but it need not be witnessed or conform in any other respect to the statutory health care power.
If you have questions about the use of any form, you may want to consult your physician, other health care provider, and/or any attorney.

POWER OF ATTORNEY FOR HEALTH CARE

1. I,_____ , hereby revoke all prior powers of attorney for health care executed by me and appoint, _____, as my attorney- in-fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care, and placement in a short or long term care facility and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue.

A. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others.

B. Effective upon my death, my agent has the full power to make an anatomical gift of the following:
(NOTE: Initial one. In the event none of the options are initialed, then it shall be concluded that you do not wish to grant your agent any such authority.)

_____ Any organs, tissues, or eyes suitable for transplantation or used for research or education.
_____Specific organs:
_____I do not grant my agent authority to make any anatomical gifts.

C. My agent shall also have full power to authorize an autopsy and direct the disposition of my remains. I intend for this power of attorney to be in substantial compliance with Section 10 of the Disposition of Remains Act. All decisions made by my agent with respect to the disposition of my remains, including cremation, shall be binding. I hereby direct any cemetery organization, business operating a crematory of columbarium or both, funeral director or embalmer, or funeral establishment who receives a copy of this document to act under it.

D. I intend for the person named as my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records, including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and regulations thereunder. I intend for the person named as my agent to serve as my “personal representative” as that term is defined under HIPAA and regulations there under.

(i) The person named as my agent shall have the power to authorize the release of information governed by HIPAA to third parties.

(ii) I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau, Inc., or any other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment for me for such services to

give, disclose, and release to the person named as my agent, without restriction, all of my individually identifiable health information and medical records, regarding any past, present, or future medical or mental health condition, (including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug or alcohol abuse, and mental illness (including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act.)

(iii) The authority given to the person named as my agent shall supersede any prior agreement that I may have with my health care providers to restrict access to, or disclosure of, my individually identifiable health information. The authority given to the person named as my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider. The authority given to the person named as my agent to serve as my "personal representative" as defined under HIPAA and regulations thereunder and to access my individually identifiable health information or authorize the release of the same to third parties shall take effect immediately, even if I designate in Paragraph 3 of this document that this agency shall otherwise take effect at some future date.

(NOTE: The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care including withdrawal of food and water and other life-sustaining measures, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to make an anatomical gift, authorize autopsy or dispose of remains, you may do so in the following paragraphs.)

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations:

(NOTE: Here you may include any specific limitations you deem appropriate, such as: your own definition of when life-sustaining measures should be withheld; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc. Initial those that apply, if any.)

_____My agent shall not authorize a blood transfusion.
_____My agent shall not revoke my DNR Order or instruct my physician to revoke my DNR Order.
_____My agent shall not authorize amputation.
_____Other:

(NOTE: The subject of life-sustaining treatment is of particular importance. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. If you agree with one of these statements, you may initial that statement; but do not initial more than one. These statements serve as guidance for your agent,

who shall give careful consideration to the statement you initial when engaging in health care decision-making on your behalf.)

I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and my quality of life as well as the possible extension of my life in making decisions concerning life-sustaining treatment. I specifically declare that in the event interventional treatments and procedures are no longer warranted, that I want all comfort measures provided to me to relieve any suffering, pain or discomfort I may be experiencing.

Initialed: _____

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in the opinion of my attending physician, in accordance with reasonable medical standards at the time of reference, in a state of "permanent unconsciousness" or suffer from an "incurable or irreversible condition" or "terminal condition," as those terms are defined in Section 4-4 of the Illinois Power of Attorney Act. If and when I am in one of these states or conditions, I want life-sustaining treatment to be withheld or discontinued.

Initialed: _____

I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards without regard to my condition, the pain and suffering which I shall endure, the quality of my life, the chances I have for recovery or the cost of the treatment and procedures. I understand that in order to accomplish the extension of my life to the greatest extent possible, that my physician and other care providers may be limited in their ability to provide pain relief and/or comfort measures as they may interfere with the extension of my life to the greatest extent possible.

Initialed: _____

(NOTE: This power of attorney may be amended or revoked by you in the manner provided in Section 4-6 of the Illinois Power of Attorney Act. Your agent can act immediately, unless you specify otherwise; but you cannot specify otherwise with respect to your "personal representative" under subparagraph D(iii).)

3. This power of attorney shall become effective: Immediately

(NOTE: Insert a future date or event during your lifetime, such as a court determination of your disability or a written determination by your physician that you are incapacitated, when you want this power to first take effect.)

(NOTE: If you do not amend or revoke this power, or if you do not specify a specific ending date in paragraph 4, it will remain in effect until your death; except that your agent will still have the

authority to donate your organs, authorize an autopsy, and dispose of your remains after your death, if you grant that authority to your agent.)

4. This power of attorney shall terminate: upon my written revocation.

(NOTE: Insert a future date or event, such as court determination that you are not under a legal disability or a written determination by your physician that you are not incapacitated, if you want this power to terminate prior to your death.)

(NOTE: You cannot use this form to name co-agents. If you wish to name successor agents, insert the names and addresses of the successors in paragraph 5.)

5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent: _____

For the purpose of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor, or an adjudicated incompetent or disabled person, or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

(NOTE: If you wish to, you may name your agent as guardian of your person if a court decides that one should be appointed. To do this, retain paragraph 6, and the court will appoint your agent if the court finds that this appointment will serve your best interests and welfare. Strike out paragraph 6 if you do not want your agent to act as guardian.)

6. If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Date:_____ Sign:_____
Client's Name

The principal has had an opportunity to review the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence. The undersigned witness certifies that the witness is not: (a) the attending physician or mental health service provider or a relative of the physician or provider; (b) an owner, operator, or relative of an owner or operator of a health care facility in which the principal is a patient or resident; (c) a parent, sibling, descendant, or any spouse of such parent, sibling, or descendant of either the principal or any agent or successor agent under the foregoing power of attorney, whether such relationship is by blood, marriage, or adoption; or (d) an agent or successor agent under the foregoing power of attorney.

Dated:_____ Signed:_____
(witness)

Address:_____ Print name: _____
(witness)

(NOTE: You may, but are not required to, request your agent and successor agents to provide specimen signatures below. If you include specimen signatures in this power of attorney, you must complete the certification opposite the signatures of the agents.)

Specimen signatures of agent (and successors).	I certify that the signatures of my agent (and successors) are correct.
_____ (agent)	_____ (principal)
_____ (successor agent)	_____ (principal)
_____ (successor agent)	_____ (principal)

(NOTE: The name, address, and phone number of the person preparing this form or who assisted the principal in completing this form is optional.)

AGENT'S CERTIFICATION AND ACCEPTANCE OF AUTHORITY

I,_____, certify that the attached is a true and correct copy of a power of attorney naming the undersigned as agent or successor agent for _____.

I certify that to the best of my knowledge the principal had the capacity to execute the power of attorney, is alive, and has not revoked the power of attorney, my powers as agent have not been altered or terminated, and the power of attorney remains in full force and effect.

If I am the successor agent, I certify to the best of my knowledge that the agent_____who preceded me in appointment is unavailable due to:

(NOTE: Initial all that apply.)

_____Death
_____Resignation
_____Absence (Unavailability)
_____Illness
_____Incapacity

I accept appointment as agent under this power of attorney.

This certification and acceptance is made under penalty of perjury. Perjury is defined in Section 32-2 of the Criminal Code of 1961, and is a Class 3 felony.

Dated:_____

Signed:_____
(agent)

Printed name:_____

Address:_____

Phone:_____