

DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES (Living Will) AND

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS (Medical Power of Attorney)

I. DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES

If I should have an incurable or irreversible condition that will result either in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery, it is my desire that my life not be prolonged by the administration of life-sustaining procedures. If I am unable to participate in my health care decisions, I direct my attending physician to withhold or withdraw life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

This declaration is subject to any specific instructions or statement of desires I have added in "Additional Provisions" below.

II. POWER OF ATTORNEY FOR HEALTH CARE DECISIONS		
Ι,	, born	, designate
(Type or Print) Name of Agent, Street Addi	race City State 7in Code and Dhon	a Number
as my attorney in fact (my agent) and give to my a		
This power exists only when I am unable, in the		
health care decisions. The attorney in fact must		
document or otherwise made known.	act consistently with my de	incs as stated in this
Except as otherwise specified in this docum	ent this document gives my	gent the nower where
otherwise consistent with the laws of the State of		
care or stopping health care which is necessary to h		ician not giving neath
This document gives my agent power to m	-	ny behalf, including to
consent, to refuse to consent, or to withdraw con		•
maintain, diagnose, or treat a physical or mental or		
my desires and any limitations included in this doc		
I hereby revoke all prior Durable Powers O		cision.
OPTIONAL: If the person designated as agent a	•	
person to serve instead:	,	
(Type or Print) Name of Alternate, Street Ad	dress City State Zin Code and Pho	ne Number
OPTIONAL: ADDITIONAL PROVISIONS - Ins		
any):	1	
•,		
YESNOIn the event that medical profession	•	
to the use of life-sustaining procedures, including		
required to complete the organ donation. Nothing	g in this paragraph shall be c	construed to expand or

detract from the laws related to anatomical gifts as outlined in the Iowa Code, Chapter 142C. The

purpose of this paragraph is to practically and medically make organ donation possible.

Signed on		
	Your Signature (Declarant/Principal)	
Address, Street, City, State and Zip	Type or Print Your Name	
NOTARY PUBLIC OR TWO WITNESSES FORMS. IF YOU WANT TO EXECUTE I MEDICAL POWER OF ATTORNEY, BUT NO FROM THE IOWA STATE BAR ASSOCIA	ST BE SIGNED OR ACKNOWLEDGED BEFORE A SEE REVERSE FOR NOTARY OR WITNESS EITHER A LIVING WILL DECLARATION OR A OT BOTH, SEPARATE FORMS ARE AVAILABLE TION. IF YOU HAVE QUESTIONS REGARDING COMPLETE IT, YOU SHOULD CONSULT AN	
NOTARY PUBLIC FORM		
STATE OF, COUNTY This record was acknowledged before me	Solution Service on Service on Service on Service on Service S	
	Signature of Notary Public	
We, the undersigned, hereby state that wand the Declarant/Principal and we witnessed the by another person acting on behalf of the Principal; that neither of us is appointed as attachealth care providers who are presently treating	WESS FORM we signed this document in the presence of each other e signing of the document by the Declarant/Principal or Declarant/Principal at the direction of the Declarant/ corney in fact by this document; that neither of us are the Declarant/Principal, or employees of such a health at least 18 years of age, and that at least one of us is not riage or adoption.	
Signature of First Witness	Signature of Second Witness	
Type or Print Name of Witness	Type or Print Name of Witness	
Street Address, City, State and Zip Code	Street Address, City, State and Zip Code	

GENERAL INFORMATION REGARDING THIS DOCUMENT

- 1. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. "Life-sustaining procedure" means any medical procedure, treatment, or intervention which utilizes mechanical or artificial means to sustain, restore, or supplement a spontaneous vital function, and when applied to a person in a terminal condition, would serve only to prolong the dying process. "Life sustaining procedure" does not include administration of medication or performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.
- 2. The terms "health care" and "life-sustaining procedure" include nutrition and hydration (food and water) only when provided parenterally or through intubation (intravenously or by feeding tube). Thus, this document authorizes withholding nutrition or hydration that is provided intravenously or by feeding tube. If this is not what you want, you should set forth your specific instructions in the space provided on page 1.
- 3. The following individuals shall not be designated as the attorney in fact to make health care decisions under a durable power of attorney for health care:
 - a. A health care provider attending the principal on the date of execution.
 - b. An employee of such a health care provider unless the individual to be designated is related to the principal by blood, marriage, or adoption within the third degree of consanguinity.
- 4. The power of attorney for health care decisions or the declaration relating to use of life-sustaining procedures may be revoked at any time and in any manner by which the principal/declarant is able to communicate the intent to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending health care provider upon its communication to the provider by the principal/declarant or by another to whom the principal/declarant has communicated the revocation.
- 5. It is the responsibility of the principal/declarant to provide the attending health care provider with a copy of this document.
- 6. A declaration relating to use of life-sustaining procedures will be given effect only when the declarant's condition is determined to be terminal or the declarant is in a state of permanent unconsciousness, and the declarant is not able to make treatment decisions.

SUGGESTIONS AFTER FORM IS PROPERLY SIGNED, WITNESSED OR NOTARIZED

- 1. Place original in a safe place known and accessible to family members or close friends.
- 2. Provide a copy to your doctor.
- 3. Provide a copy(s) to family member(s).
- 4. Provide a copy to the designated attorney in fact (agent) and to alternate designated attorneys in fact (if any).

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO NOMINATED HEALTH CARE ATTORNEY-IN-FACT

Pursuant to the terms of a Durable Power of Attorney, Health Care Decisions, (or Combined Living Will and Medical Power of Attorney) (HCPOA) dated _________, in which the undersigned is the grantor, the power becomes effective in the event of my disability or incapacity.

AUTHORIZATION TO RELEASE INFORMATION:

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 other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release to the person or persons designated in this document to act as my agent such of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition

(including all specially protected health infor conditions specifically authorized by me to be or a check mark:	E E	
sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV); behavioral and mental health; alcohol, drug and other substance abuse; and genetic-related information);		
Signature of Principal	Date	

relating to my ability to make health care decisions. The purpose of this request is to assist in determining whether the person designated to act as my agent should act as my agent. This authorization expires when I die or when revoked by me by a written revocation signed by me and delivered to the entity from which information is being requested prior to the time information is being requested.

I understand I can revoke this authorization by delivering a written statement of revocation to any entity I have authorized to give, disclose and release information. The revocation is effective only as to those entities to whom the written statement revocation is given and only after the time of delivery. I also understand that I have the right to inspect the disclosed information at any time. My treatment, payment, enrollment or eligibility for benefits with an entity that I have authorized to release information is not conditioned on my signing this authorization. I know that once the information I have authorized to be released is released it is subject to re-disclosure by the recipient and is no longer protected by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto, as amended from time to time.

THE AUTHORITY TO ACT AS PERSONAL REPRESENTATIVE

In addition to the other powers granted by the HCPOA, I grant to my agent the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and its regulations (HIPAA) during any time that my agent (hereinafter referred to in subsequent clauses of this paragraph as my "HIPAA personal representative") is exercising authority under this document.

Pursuant to HIPAA, I specifically authorize my receive and review any information regarding my pl limitation all HIPAA-protected health information, med behalf any authorizations, releases, or other documents information and to consent to the disclosure of this personal representative to execute on my behalf any documents that my HIPAA personal representation bated on	nysical or mental health, including without lical and hospital records; to execute on my that may be required in order to obtain this information. I further authorize my HIPAA ments necessary or desirable to implement the
	, Grantor