Durable Power of Attorney for Health Care: Kansas

I, ________________________________, hereby appoint the following person as my attorney-in-fact for health care decisions:

Name: ______________________________________

Address: _____________________________________

City/State/Zip: ________________________________

Phone: ______________________________________

Alternate attorney-in-fact.

Name: ______________________________________

Address: ____________________________________

City/State/Zip: ________________________________

Phone: ______________________________________

This is a durable power of attorney, and the authority of my attorney-in-fact shall not terminate if I become disabled or in the event of later uncertainty as to whether I am alive or dead. This durable power of attorney shall become effective immediately. This authority shall not include the ability to revoke or invalidate any declaration made in accordance with the Natural Death Act (a "Living Will" or similarly titled document).

My attorney-in-fact shall have the authority to, on my behalf:

1. Consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, and to make decisions about organ donation, autopsy, and disposition of the body.
2. Make any and all arrangements at any hospital, psychiatric hospital, or psychiatric treatment facility, hospice, nursing home, or similar institution in Kansas or any other state or country; make arrangements for my release and removal from any institution; employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists, or any other person who is licensed, certified, authorized, or permitted by law to administer health care, as the agent shall deem necessary for my physical, mental, and emotional well-being;

3. Request, receive, and review any verbal or written information regarding my personal affairs or physical or mental health, including medical and hospital records, to execute any releases that may be required to obtain this information, and to consent to the disclosure of this information. I hereby waive my patient-physician privileges in relation to this Durable Power of Attorney for Health Care Decisions. Further, I hereby knowingly and purposefully waive any and all rights I may now have an in the future under the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, and the Department of Health and Human Services (HHS) Privacy Rule of 2000 (Standards for Privacy of Individually Identifiable Health Information) and thereby allow my doctors and all other health care providers, health care plans and clearinghouses, including the medical staff and short term medical facilities, to release all information regarding my medical history, status, diagnosis and treatment to my attorney and agent herein set out.

I hereby revoke any previous Durable Power of attorney for Health care Decisions. This revocation does not extend to any previous General Durable Power of Attorney. I reserve the right to revoke this document by subsequent writhing executed in the same manner as this document. This document shall continue in full effect until the earlier of the following: (1) my death; or (2) my revocation of this document.

Signed this _________ day of _____________, 20______

Signature: ______________________________________

THIS POWER OF ATTORNEY DIRECTIVE MUST BE SIGNED BY TWO WITNESSES AND/OR A NOTARY PUBLIC.

Witness signature: ____________________________________ Date: _____________

Witness signature: ____________________________________ Date: _____________

STATE OF KANSAS, COUNTY OF _____________________________________

The foregoing Durable Power of Attorney for Health Care was acknowledged before me

this ___________day of ____________, 20___

by_____________________________________ (the declarant).

___________________________ ___________________

Notary Public My Commission Expires