MONTROSE
MEMORIAL HOSPITAL
800 South Third Street
Montrose, CO 81401
970-249-2211

Medical Durable Power of Attorney for Health Care Decisions

I, _____, Declarant, hereby appoint: _____
PRINT OR TYPE YOUR NAME NAME OF AGENT

_____ _____
AGENT'S HOME PHONE # WORK PHONE # AGENT'S HOME ADDRESS

as my agent to make health care decisions for me if and when I am unable to make my own health care decisions. This gives my agent the power to consent, to refuse or stop any health care, treatment, service, or diagnostic procedure. My agent also has the authority to talk with health care personnel, get information and sign forms necessary to carry out those decisions.

If the person named as my agent is not available or is unable to act as my agent, then I appoint the following person(s) to serve in the order listed below:

2. _____ 3. _____
AGENT NAME AGENT NAME

_____ _____
AGENT'S HOME PHONE # WORK PHONE # AGENT'S HOME PHONE # WORK PHONE #

By this document I intend to create a Medical Durable Power of Attorney which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity.

My agent shall make health care decisions as I may direct below or as I make known to him or her in some other way. If I have not expressed a choice about the health care in question, my agent shall base his/her decision on what he/she believes to be in my best interest.

a. Statement of desires concerning life-prolonging care, treatment, services, and procedures

_____

_____

_____

b. Special provisions and limitations:

_____

_____

_____

BY SIGNING HERE, I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT:

_____
SIGNATURE OF PESRSON CREATING MEDICAL DURABLE POWER OF ATTORNEY (DECLARANT) DATE

OPTIONAL BUT RECOMMENDED

Colorado law does not require this instrument to be witnessed, however; it is recommended to obtain the signature of two witnesses or a notary. This is not required by Colorado law but may make this document more acceptable in other states.

_____ _____
SIGNTAURE OF WITNESS SIGNTAURE OF WITNESS

_____ _____
HOME ADDRESS HOME ADDRESS

_____ _____
DATE DATE

See back of this form for important information regarding Medical Durable Power of Attorney for Health Care Decisions.
Once complete, put a copy in the patient's chart and give the original document to the patient.

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Important Information
Regarding this Medical Durable Power of Attorney for Health Care Decisions Form

Before signing this legal document, it is very important for you to know and understand these facts:

- This document gives the person you name as your agent the power to make health care decisions if you are unable to do so. (These decisions and powers are not limited to terminal conditions and life-support decisions.)
- After you have signed this document, you still have the right to make health care decisions for yourself if you are able to do so.
- You may state in this document any type of treatment that you want to receive or want to avoid. If you want your agent to make decisions about life-sustaining treatment, it is best to state it in your medical durable power of attorney.
- You have the right to take away the authority of your agent unless you have been determined to be incompetent by a court. If you withdraw (revoke) the authority of your agent, it is recommended that you do so in writing and give copies to all those who received the original document.
- You should not sign this document unless you understand it. You may wish to talk to other or a lawyer.
- The Medical Durable Power of Attorney form on the reverse side of this document may be used; however, it may not meet your individual needs. Other Medical Durable Power of Attorney forms are acceptable according to Colorado law. Be sure the form you sign meets your needs.
- This Medical Durable Power of Attorney form complies with Colorado law; however, witness, notary and other requirements may vary from state to state. If you should move to another state, be sure to check that state's requirements.
- Any Medical Durable Power of Attorney you choose to use should contain:
    - The name, address, and telephone number of the person you choose as your agent, and your second choice of agent to act if your first agent is unable to act for you.
    - Any instructions about treatment you do or do not wish to receive such as surgery, chemotherapy, or life-sustaining treatment such as artificial feeding, kidney dialysis or breathing support, etc.