**HEALTH CARE POWER OF ATTORNEY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. I appoint \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, telephone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_as my Agent, to make health care decisions on my behalf as authorized in this document.

2. I give my Agent authority to make health care decisions on my behalf as described below whenever I have been determined to be incapable of making an informed decision about providing, withholding or withdrawing medical treatment, regardless of whether I am in Virginia at the time my Agent acts. My Agent’s authority is effective as long as I am incapable of making an informed decision.

3. “Incapable of making an informed decision” means unable to understand the nature, extent and probable consequences of a proposed medical decision or unable to make a rational evaluation of the risks and benefits of a proposed medical decision as compared with the risks and benefits of alternatives, or unable to communicate such understanding.

4. The determination that I am incapable of making an informed decision shall be made by my attending physician and a second physician or licensed clinical psychologist after a personal examination of me and shall be certified in writing. Such certification shall be required before treatment is withheld or withdrawn and before, or as soon as reasonably practicable after, treatment is provided and every 180 days thereafter while the treatment continues. If after a subsequent personal examination of me a physician affirms in writing that I have regained capacity to make an informed decision, any further decisions regarding my health care will require my informed consent.

5. In exercising the power to make health care decisions on my behalf my Agent shall be guided by my medical diagnosis, prognosis and the information provided by my physicians as to the intrusiveness, pain, risks and side effects associated with treatment or non-treatment, and shall make a choice for me based upon what my Agent believes to be in my best interest.

6. I release my Agent from the obligation to base decisions made for me on my religious beliefs, basic values or treatment preferences, except to the extent they have been made in writing and delivered to my Agent. Decisions authorized by this document shall be made in the sole and absolute discretion of my Agent. I release my Agent from all liability for the consequences of decisions made by my Agent in good faith and authorized by this document. My estate shall hold harmless and indemnify my Agent from such liability, including attorney’s fees and costs to defend claims.

7. I appoint my Agent as my personal representative for purposes of the Health Insurance Portability and Accountability Act of 1996 and its regulations ("HIPAA").

8. My Agent shall have full power and authority, under the circumstances and subject to the conditions recited in this document, to take all actions and make all decisions on my behalf regarding my physical and mental health, including but not being limited to the following:

a. To consent, refuse or withdraw consent to medical care, treatment, surgical procedures, diagnostic procedures, medication and the use of mechanical or other procedures that affect bodily function, including but not limited to artificial respiration, artificially administered nutrition and hydration, and cardiopulmonary resuscitation. This authorization also specifically includes the power to direct and consent to the writing of a “No Code” or “Do Not Resuscitate Order” or an “Emergency Medical Services Do Not Resuscitate Order” by any health care provider.

b. To admit or discharge me from the care and custody of physicians, hospitals, nursing homes, convalescent centers, homes for adults, hospice and other facilities.

c. To request, receive and review information, oral or written, regarding my physical or mental health, including medical and hospital records, including information that would otherwise be private and protected by HIPAA, and to execute releases and other documents that may be required in order to obtain such information, and to disclose such information to such persons or entities as my Agent shall deem appropriate. I authorize and direct doctors, hospitals and other health care providers to release such records to my Agent.

d. To employ and discharge health care providers, companions, geriatric care managers, hospice personnel and other persons, including any member of my extended family, to provide health or companionship services that may be helpful in assisting me in the enjoyment of life, regardless of whether I remain in a private home or am admitted to a group care facility.

e. To exercise my right of privacy and my right to be left alone as they relate to my medical treatment, even though the exercise of such rights might hasten my death or be against conventional medical advice.

f. To consent, refuse or withdraw consent to pain relief therapies, including unconventional pain relief therapies, even if their use may lead to permanent physical damage, addiction or even hasten the moment of, but not intentionally cause, my death.

g. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

h. To represent me in connection with medical services reimbursed or provided by, or not reimbursed or provided by, any health insurer, health care provider, or health maintenance organization. My Agent shall have access to all my medical records, including specifically those that would otherwise be private and protected by HIPAA, and full authority to act as my advocate in administrative, court or other proceedings on my behalf, and may consent on my behalf to arbitration, mediation or other alternative dispute resolution processes concerning my health care.

i. To authorize my participation in any health care study that offers the prospect of direct therapeutic benefit to me and is approved by an institutional review board or research review committee in accordance with applicable federal or state law.

j. To restrict or permit visitation by any person at any time.

9. My Agent shall not be liable for any costs of my medical care. My Agent’s signature on consent or admission papers shall not make my Agent liable for such costs.

10. The execution of this document revokes all medical directives previously executed by me. This Health Care Power of Attorney shall not terminate upon my disability.

11. A person, firm or corporation relying upon this Health Care Power of Attorney

shall be fully protected unless and until actual notice of its revocation is received.

I am emotionally and mentally competent to make this Health Care Power of Attorney

and understand its purpose and effect.

Signed on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Declarant signed the foregoing Advance Medical Directive in my presence.

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Witness

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Witness

COMMONWEALTH OF VIRGINIA,

COUNTY OF FAIRFAX, to-wit:

I, the undersigned Notary Public in and for the aforesaid jurisdiction, do hereby certify that this day personally appeared before me \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, whose name is signed to the foregoing Health Care Power of Attorney, and acknowledged the same before me in the aforesaid jurisdiction.

Given under my hand on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Notary Public