MEDICAL PROCURATION

FROM: _____ **STATE OF LOUISIANA**

TO: _____ **PARISH OF** _____

I, _____, a Notary Public in and for the Parish of _____ and with statewide jurisdiction for the State of Louisiana, do hereby certify that _____, personally came and appeared before me as the **PRINCIPAL**, and executed this Durable Power of Attorney for Healthcare in said State and Parish, and acknowledged said Durable Power of Attorney for Healthcare as the Principal's voluntary act. Principal states:

I, _____, hereinafter **PRINCIPAL**, hereby appoint:

Name: _____

Address of Residence: _____

Telephone #: _____

as my **AGENT** to make healthcare decisions for me if I become unable to make my own healthcare decisions such as the following:

_____ A. Grant, refuse, or withdraw consent on my behalf for any healthcare service, treatment, or procedure, even though my death may ensue.

_____ B. Talk to healthcare personnel, get information, have access to medical records and sign forms necessary to carry out these decisions.

_____ C. Authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service.

_____ D. Contract on my behalf for any healthcare-related services or facility (without my agent incurring personal financial liability for such contracts) such as surgery, medical expenses, and prescriptions.

_____ E. Make decisions regarding surgery, medical expenses, and prescriptions. With this document, I intend to create a durable power of attorney for healthcare, which shall take effect upon and only during any period in which, in the opinion of my attending physician, I am unable to make or communicate a choice regarding a particular healthcare decision. My Agent shall make healthcare decisions as I direct below or as I make known to them in some other way. If my Agent is unable to determine the choice I would want to make, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interest.

With this document, I authorize any person, organization, or entity involved with my healthcare to disclose and release to my Agent any and all of my individually identifiable health information and medical records in accordance with HIPAA.

SPECIAL PROVISIONS AND LIMITATIONS. I do NOT want the following treatments:

_____

_____

_____

To the extent that I am permitted by law to do so, I herewith nominate my Agent to serve as the curator of my person, and/or in any similar representative capacity. If I am not permitted by law to make a nomination, then I request in the strongest possible terms that any court consider this nomination.

No person who relies in good faith upon representations by my Agent shall be liable to me, my estate, my heirs or assigns for recognizing my Agent's authority.

The powers delegated under this Power of Attorney are separable, so that the invalidity of one or more powers shall not affect any others.

Signature page follows

I understand the full import of this designation and I am emotionally and mentally competent to make this appointment and grant these powers and authorities.

I sign my name to this form on _____, 20____ at _____, _____ Parish, Louisiana

PRINCIPAL Signature: _____

Print **PRINCIPAL** Name: _____

Witness:_____

Printed Name:_____

City, Parish, and State of Residence:_____

Witness:_____

Printed Name:_____

City, Parish, and State of Residence:_____

_____

Notary Public:_____

Notary No. _____