

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, residing at _____, _____, Montana, do hereby make, constitute, nominate and appoint _____, presently residing at _____, Montana, as my true and lawful attorney-in-fact to act for me and in my place and stead for the purpose of making any and all decisions regarding my health, medical care and treatment at any time that I may be, by reason of physical, mental disability, incompetency or incapacity, incapable of making decisions on my behalf.

- 1.** I grant said attorney-in-fact complete and full authority to do and perform all and every act and thing whatsoever requisite, proper and necessary to be done in the exercise of the rights herein granted, as fully for all intents and purposes as I might or could do if personally present and able with full power of substitution or revocation, hereby ratifying and confirming all that said attorney-in-fact shall lawfully do or cause to be done by virtue of this power of attorney and the rights and powers granted herein.
- 2.** If, at any time, I am unable to make or communicate decisions concerning my medical care and treatment, by virtue of physical, mental or emotional disability, incompetency, incapacity, illness or otherwise, my said attorney-in-fact shall have the authority to make all health care decisions and all medical care and treatment decisions for me and on my behalf, including consenting or refusing to consent to any care, treatment, service or procedure to maintain, diagnose or treat my mental or physical condition.
- 3.** In the absence of my ability to give directions regarding my health care, it is my intention that my said attorney-in-fact shall exercise this specific grant of authority and that such exercise shall be honored by my family, physicians, nurses, and any other health care provider(s) or facility in which or by which I may be treated.
- 4.** This power of attorney is durable and will continue to be effective if I become disabled, incapacitated, or incompetent.
- 5.** I, specifically direct all health care providers, including physicians, nurses, therapists and medical and hospital staff to follow the directions of my attorney-in-fact and such decisions are superior to and shall take precedence over any decisions made by any member of my family. My attorney in fact shall have access to all medical information and records, and HIPPA shall not prevent said access.
- 6.** The rights, powers and authority of said attorney-in-fact herein granted shall commence and be in full force and effect immediately.
- 7.** If any agent named by me dies, becomes incompetent resigns or refuses to

accept the office of agent, I name the following persons (each to act alone and successively, in the order named) as successor(s) to the agent:

A. _____

B. _____

8. Special instructions: On the following lines I give special instructions limiting or extending the powers granted to my agent.

10. I hereby designate _____, a licensed physician, to determine whether I am unable to make or communicate decisions concerning my medical care and treatment by virtue of my physical, mental, or emotional disability, incompetency, incapacity, illness or otherwise. This determination will be provided in writing and attached to this document.

Dated this _____ day of _____, _____.

Signature of Principal:

STATE OF MONTANA)

: ss.

County of _____)

On this day _____ of, _____, 20____, before me personally appeared _____ known to me to be the person whose name is subscribed to the within instrument and acknowledged to me that she/he executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the _____ day of _____, 20____.

Notary Public for the State of Montana
Residing at _____
My Commission expires _____