

## Durable Power of Attorney for Health Care

I, \_\_\_\_\_ of, \_\_\_\_\_, Michigan,  
(Name) (City)

hereby appoint \_\_\_\_\_,  
(Patient Advocate)

residing at \_\_\_\_\_,  
(Patient Advocate Address)

as my attorney in fact (herein called patient advocate) with the following power to be exercised in my name and for my benefit, including, but not limited to, making decisions regarding my care, custody or medical treatment. This power of attorney has effect only if I become unable to participate in medical treatment decisions.

If the first individual is unable, unwilling, or unavailable to serve as my patient advocate, then I designate \_\_\_\_\_ residing at \_\_\_\_\_,  
(Successor Patient Advocate)  
\_\_\_\_\_, to serve as my patient advocate.  
(Successor Advocate Address)

With respect to my personal care, the advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of my person, including, but not limited to:

*(If any of the following do not apply, I may cross them out and place my initials next to the cross out.)*

- A. To have access to and control over my medical and other personal information.
- B. To employ and discharge physicians, nurses, therapists and any other care providers, and to pay them reasonable compensation.
- C. To give an informed consent or an informed refusal on my behalf with respect to any medical care; diagnostic, surgical, or therapeutic procedure; or other treatment of any type or nature, including life-sustaining treatments such as artificial nutrition and hydration.
- D. To execute waivers, medical authorizations and such other approval as may be required to permit or authorize care which I may need, or to discontinue care that I am receiving.
- E. Decisions that could or would allow my death.

My advocate shall be guided in making such decisions by what I have told my advocate about personal preferences regarding such care. Some of those preferences may be recorded below: *(Recording any of your preferences is OPTIONAL.)*

My wishes concerning care are as follows:

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It is my intent that my family, the medical facility, and any doctors, nurses and other medical personnel involved in my care not be liable for implementing the decisions of my patient advocate or honoring wishes expressed in this designation.

Photo copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

This document is to be treated as a durable Power of Attorney and shall survive my disability or incapacity.

This document is signed in the state of Michigan. It is my intent that the laws of the state of Michigan govern all questions concerning its validity, the construction of its provisions and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be.

I voluntarily sign this durable Power of Attorney after careful consideration. I understand its meaning and accept its consequences.

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(Signature) (Date)

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(Social Security Number)

**WITNESSES:**

(A witness shall not sign this Durable Power of Attorney unless the person appears to be of sound mind and under no duress, fraud, or undue influence.)

Name and addresses of witnesses:

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(Witness Signature)

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(Witness Signature)

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(A witness must be a disinterested individual and may not be the person's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, physician, patient advocate, an employee of a life or health insurance provider for the patient, an employee of a health facility that is treating the patient, or an employee of a home-for-the-aged.)

## Acceptance by Patient Advocate

- A.** This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.
- B.** A patient advocate shall not exercise powers concerning the patient's care, custody and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.
- C.** A patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.
- D.** A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights and responsibilities.
- E.** A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.
- F.** A patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.
- G.** A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.
- H.** A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, Being Section 333.20201 of the Michigan Compiled Laws.

I understand the above conditions and I accept the designation as patient advocate for:

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Dated: \_\_\_\_\_ Signed: \_\_\_\_\_  
(Patient Advocate)

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_  
(Successor Patient Advocate)