

HEALTH CARE POWER OF ATTORNEY - Short Form

Instructions and Form

General Instructions: Use this Health Care Power of Attorney form if you want to select a person to make future health care decisions for you so that if you become too ill or cannot make those decisions for yourself the person you choose and trust can make medical decisions for you. Talk to your family, friends and others you trust about your choices. Also, it's a good idea to talk with professional such as your doctor, clergyperson and a lawyer before you sign this form. Be sure you understand the importance of this document. If you decide this is the form you want to use, complete the form. **Do not sign this form** until your witness or a Notary Public is present to witness the signing.

1. Information about me (I am called the "Principal"):

My Name: _____

My Age: _____

My Address: _____

My Date of Birth: _____

City, State, Zip: _____

Home Telephone: _____

Work Telephone: _____

Cell Telephone: _____

I designate the following person to serve as my Agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care including mental health care:

Name: _____

Home Telephone: _____

Street Address: _____

Work Telephone: _____

City, State, Zip: _____

Cell Telephone: _____

I choose the following person to act as an Alternate Representative to make healthcare decisions for me if my first representative is unavailable, unwilling or unable to serve or to continue to serve:

Name: _____

Home Telephone: _____

Street Address: _____

Work Telephone: _____

City, State, Zip: _____

Cell Telephone: _____

By initialing here, I consent to giving my Agent the power to admit me to an inpatient or partial psychiatric hospitalization program, including a level one behavioral health facility. Please initial here: (INITIAL IF YOU CONSENT)

This Health Care Power of Attorney is effective when I am unable to make or to communicate health care decisions. All of my Agent's actions under this Power during any period when I am unable to make or communicate health care decisions or when it is unclear whether I am dead or alive have the same effect on my heirs, devisees, and personal representatives as if I were alive, competent and acting for myself.

I have _____ I have not _____ completed and attached a Living Will to provide specific direction to my Agent in situations that may occur during any period when I am unable to make or communicate healthcare decisions or after my death. My Agent is directed to follow those choices I have initialed in the Living Will.

I have _____ I have not _____ completed a Pre-hospital Medical Directive pursuant to Section 36-3251, Arizona Revised Statutes.

This health care directive is made under Section 36-3221, Arizona Revised Statutes and continues in effect for all who may rely on it, except those to whom I have given notice of its revocation or if it is revoked by an order of a court.

Principal Signature or Verification

I am signing this Healthcare Power of Attorney as follows:

Signature or Mark of Principal: _____

Printed Name: _____

Date: _____

Signature of Witness or Notary Public

Note: At least one adult witness OR a Notary Public must witness the signing of this document and then sign it. The witness or Notary Public CANNOT be anyone who is: (a) Under the age of 18; (b) Related to you by blood, adoption or marriage; (c) Entitled to any part of your Estate; (d) Appointed as your representative; or (e) Involved in providing your healthcare at the time this document is signed.

1. Witness Section (Witness shall select one of the two boxes below, and sign and date the document as required).

- **Witness Certification:** I certify that I have witnessed the signing of this document by the Principal. The person who signed this Healthcare Power of Attorney appeared to be of sound mind and under no pressure to make specific choices or to sign the document. I understand the requirements of being a witness and I confirm the following:
 - I have not been designated to make medical decisions for the person who signed this Healthcare Power of Attorney;
 - I am not directly involved with providing healthcare to this person;
 - I am not related to this person by blood, marriage, or adoption;
 - I am not entitled to any part of this person's estate upon his death under a Will or by operation of law.

OR

- **Witness Verification:** The Principal is physically unable to sign or mark this document, so as witness I am verifying the Principal's desires as follows:

I believe that this Healthcare Power of Attorney accurately expresses the wishes communicated to me by the Principal of this document. He/she is physically unable to sign or mark this document at this time. I verify that he/she directly indicated to me that the Healthcare Power of Attorney expresses his/her wishes and that he/she intends to adopt the Healthcare Power of Attorney document at this time.

- **Witness Certification:** I certify that I have witnessed the signing of this document by the Principal. The person who signed this Healthcare Power of Attorney appeared to be of sound mind and under no pressure to make specific choices or to sign the document. I understand the requirements of being a witness and I confirm the following:
 - I have not been designated to make medical decisions for the person who signed this Healthcare Power of Attorney;
 - I am not directly involved with providing healthcare to this person;
 - I am not related to this person by blood, marriage, or adoption;
 - I am not entitled to any part of this person's estate upon his death under a Will or by operation of law.

Witness Name (Printed): _____

Witness Signature: _____

Witness Address: _____

Date: _____

2. **Notary Public:** Note: A Notary Public is only required if no witness signed above.

STATE OF ARIZONA)
) ss.
County of)

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Healthcare Power of Attorney has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to the person signing above by blood, marriage, or adoption, nor am I a person designated to make medical decisions on his/her behalf. I am not directly involved in providing healthcare to the person signing. I am not entitled to any part of his/her estate under a Will now existing or by operation of law. In the event the person acknowledging this Healthcare Power of Attorney is physically unable to sign or mark this document, I verify that he/she directly indicated to me that this Healthcare Power of Attorney expresses his/her wishes and that he/she intends to adopt the Healthcare Power of Attorney at this time.

WITNESS MY HAND AND SEAL this _____ day of _____, 20_____.

Notary Public _____ My Commission Expires _____