# Medical Durable Power of Attorney
# of

_____

I, _____, the principal, an adult of sound mind, execute this Medical Durable Power of Attorney (subsequently called "power") pursuant to §§ 15-14-503 to 15-14-509, Colorado Revised Statutes, freely and voluntarily, with an understanding of its purposes and consequences. I intend my statements in this document to constitute clear and convincing evidence of my wishes concerning medical treatment.

## Article One
## Recitals

### Section 1.01 Designation of Healthcare Agent

I designate _____ as my attorney-in-fact and agent (subsequently called "agent") to make decisions for me related to my medical treatment, health care, personal care, and residential placement. I give to my agent all of the following powers which shall not be impaired by my disability or by lapse of time.

### Section 1.02 Successor Agent

If _____is not available or ceases to act as my agent, then I appoint _____ as my agent to act with all of the powers enumerated herein. Whenever the term "agent" is used in this document, it shall apply equally to the agent originally named and to all successors.

### Section 1.03 Duration

This instrument is not limited to a term of years; it shall terminate only upon its revocation pursuant to the provisions of this power, or upon my death, whichever event first occurs.



BUDMAN LAW, P.C., 5105 DTC PARKWAY, SUITE 150, GREENWOOD VILLAGE, CO 80111 | (303) 217-2018

### Section 1.04 General Grant

My agent has authority to do all acts related to my personal care, residential placement, and medical treatment which my agent may deem appropriate, including but not limited to the items specifically mentioned hereafter. Even if my agent is not available, I intend the following statements to guide decisions about my care and treatment.

### Section 1.05 Effect on Legal Capacity

My agent's exercise of authority shall not require or imply a formal adjudication of my incapacity.

### Section 1.06 HIPAA Personal Representative

My Agent under this instrument is hereby designated as my "Personal Representative" as defined by Public Law 104-191 and supporting CFRs, otherwise known as the Health Insurance Portability and Accountability Act of 1996, as amended, or HIPAA. This "Personal Representative" may view my medical records, execute releases of confidential information from medical providers and insurers or other third parties, and shall be considered my "personal representative" for health care disclosure under HIPAA. This authorization and consent to disclosure shall apply whether or not I continue to have the capacity to give informed consent, and is effective immediately upon signing of this instrument. I further consent to and direct covered entities to provide my protected health information to my "personal representative" at any time upon his or her request.

## Article Two
## Health and Personal Powers

### Section 2.01 Instructions Concerning Medical Evaluations and Treatment

I want to leave my (circle the applicable option) **[friends and persons who care about me] / [family]** with assurances of my love, and without the burdens of guilt or conflict. My

purposes in leaving these instructions are to alleviate uncertainty and discord that otherwise may arise in connection with decisions about my medical care **[to promote family harmony]** and to clarify instructions to my health care providers. My agent's authority includes, but is not limited to, decisions concerning consent to, and refusal of, artificial life support, medical treatment, surgery and other medical procedures; artificial nourishment and hydration; cardiopulmonary and other types of resuscitation, assisted respiration and ventilation support (including Do Not Resuscitate ("DNR") orders and CPR directives); amputation of my limbs; blood transfusions; experimental drugs and medical procedures; pharmaceutical products; and arrangements for my long term care.

**[OPTIONAL (initial if applicable): ____** When exercising these powers, my agent should bear in mind my standards for maintaining personal dignity and a meaningful quality of life. For me, quality of life requires/involves: _____. **]**

## Section 2.02 Long Term or Hospice Care

My agent is authorized to select a facility for my nursing, convalescent or hospice care and to establish my residence **[OPTIONAL (initial if applicable): ____** and placement**]** therein if, in my agent's sole and exclusive discretion, such facility provides the quality of care appropriate for my medical needs and mental condition.

**OPTIONAL (**initial the applicable provisions, if any)**:**

_____ For the purposes of arranging or providing long term care, my agent has authority to arrange for my transportation and establish my legal residence within or beyond the state of Colorado.

_____ I do not want to become a burden to my family, or to impose upon them or intrude upon their households.

_____ I prefer to receive care in a hospice rather than in a hospital as the end of my life approaches.

### Section 2.03 Medical Information and Medical Records

My agent may have access to all of my medical information and records; may disclose medical and related information concerning my treatment to appropriate persons or entities; may admit or transfer me to such hospitals, hospices, or treatment facilities as my agent deems to be in my best interests; and may retain and discharge physicians and other medical advisors.

### Section 2.04 HIPAA Protected Health Information

My agent acting under this instrument has current authority to make decisions for me related to my health care. Accordingly, I confirm that in connection therewith, my agent is my personal representative for all purposes relating to my protected health information, pursuant to HIPAA and regulations thereunder, in particular, 45 C.F.R. § 164.502(g)(1) and (2), and under Colorado state law, C.R.S. § 15-14-506(3).

### Section 2.05 Comfortable Care and Pain Relief

My comfort and freedom from pain are important for my agent and physician to maintain, insofar as possible. I authorize my agent to consent on my behalf to the administration of whatever pain-relieving drugs and surgical pain relieving procedures my agent, upon medical advice, believes may provide comfort to me, even though such drugs or procedures may lead to pharmaceutical addictions, lower blood pressure, lower levels of breathing, or may hasten my death. Even if artificial life support or aggressive medical treatment has been withdrawn or refused, I want to be kept as comfortable as possible, and I do not want to be neglected by medical or nursing staff. **OPTIONAL** (initial if applicable):

_____ I would particularly like the following persons or things to be near me or to be done for me when I am close to death because I find them comforting: _____.

## Section 2.06 Living Will

**Sign Your Initials by the Applicable Provision(s):**

_____ I have executed a living will declaration under the laws of the state of Colorado. To the extent that any provisions of this medical durable power of attorney are deemed to conflict with my living will, _____ my agent's authority / _____ my living will shall prevail.

_____ I hereby revoke all previously executed living wills. I intend that this medical durable power of attorney replace and supersede all living wills and other medical durable powers of attorney that I may have signed.

_____ I have not executed a living will declaration and I do not want my agent's powers to be limited by the terms or conditions of a living will.

If I become unconscious or incompetent in a state where my living will declaration or this medical durable power of attorney is not honored, I authorize my agent to transport me or arrange for my transportation to a jurisdiction where my medical directives will be enforceable.

## Section 2.07 Anatomical Gifts

I hereby authorize the following acts with regard to donation of my organs, tissue, bone, corneas, and other components of my body (initial next to the applicable provision):

___ I authorize my agent to make anatomical gifts on my behalf for the limited purpose of transplantation, which shall take effect upon my death, to such persons and organizations as my agent shall deem appropriate, and to execute such instruments and perform such acts as may be necessary, appropriate, incidental, or convenient in connection with such gifts.

___ I authorize my agent to make anatomical gifts on my behalf for the limited purpose of transplantation to members of my immediate family, and to execute such instruments and perform such acts as may be necessary, appropriate, incidental, or convenient in connection with such gifts.

_____ I authorize my agent to make anatomical gifts on my behalf for purposes

of medical research, and to execute such instruments and perform such acts as may be necessary, appropriate, incidental, or convenient in connection with such gifts.

___ I do not authorize my agent to make any anatomical gifts on my behalf following my death.

# Article Three
# Legal and Administrative Powers and Provisions

## Section 3.01 Guardian

The authority conferred upon my agent shall obviate the need for appointment of a guardian. However, should any proceeding commence for appointment of a guardian, I nominate my agent to act as guardian, without bond.

## Section 3.02 Third-Party Reliance

Third parties shall accept as binding the instructions and decisions of my agent regarding my medical treatment. No person or medical facility or institution shall incur any liability to me or to my estate by complying with my agent's instructions. My agent is authorized to execute consents, waivers, and releases of liability on my behalf and on behalf of my estate to all medical personnel who comply with my agent's instructions. Furthermore, I authorize my agent to indemnify and hold harmless, at my expense, any third party who accepts and acts under this power of attorney, and I agree to be bound by any such indemnity entered into by my agent.

## Section 3.03 Enforcement by Agent

I authorize my Healthcare Agent to seek on my behalf and at my expense:

a) A declaratory judgment from any court of competent jurisdiction interpreting the validity of this instrument or any of the acts authorized by this instrument, but a declaratory judgment is not required for my Healthcare Agent to perform any act authorized by this instrument; and/or

b) an injunction requiring compliance with my Healthcare Agent's instructions by any person providing medical or personal care to me; or

c) actual and punitive damages against any person responsible for providing medical or personal care to me who willfully fails or refuses to follow my Healthcare Agent's instructions.

### Section 3.04 Release of Healthcare Agent's Personal Liability

My agent shall not incur any personal liability to me or my estate arising from the (circle the applicable option) **[good faith] / [reasonable]** exercise of discretion or performance of acts and duties relating to my medical treatment and personal care.

### Section 3.05 Reimbursement of Healthcare Agent

My agent shall be entitled to reimbursement for all reasonable expenses arising from the performance of acts and duties relating to my medical treatment and personal care pursuant to this document.

**OPTIONAL (initial if applicable):** _____ In addition, my agent shall be entitled to reasonable compensation for services actually rendered while acting as my agent.

### Section 3.06 Copies Effective as Originals

Photocopies of this instrument are effective and enforceable as originals, and third parties are entitled to rely on photocopies of this instrument for the full force and effect of all stated terms. The word *photocopies* includes facsimiles, digital, or other reproductions.

### Section 3.07 Interstate Enforceability

My intention is that the terms of this instrument be honored in any jurisdiction, regardless of its conformity to that jurisdiction's technical requirements and legal formalities.

### Section 3.08 Severability

The invalidity or unenforceability of any provision of this instrument does not affect the validity or enforceability of any other provision of this instrument. If any provision of this instrument is declared invalid for any reason, the remaining provisions will remain in full force and effect.

## Section 3.09 Amendment and Revocation

I reserve the right to revoke my Healthcare Agent's authority orally or in writing.

## Section 3.10 Revocation of Prior Powers

Unless specifically excepted in this instrument, this Medical Durable Power of Attorney supersedes any prior medical durable power of attorney that I have executed. But this instrument does not affect any other unrelated powers previously conveyed by me through general or limited powers of attorney, or my Living Will; these powers and Living Will are to continue in full force until revoked by me or otherwise terminated.

Dated: _____, 20___

_____

_____, Principal

We, _____ and _____, the witnesses, sign our names to this instrument, being first duly sworn, and do hereby declare to the undersigned authority that signs and executes this instrument and that (circle the applicable option) **[he]** / **[she]** signs it willingly (or willingly directs another to sign for **[him]** / **[her]**) and that **[he]** / **[she]** executes it as **[his]** / **[her]** free and voluntary act for the purposes therein expressed.

STATE OF COLORADO )
) ss.
COUNTY OF _____ )

Subscribed and acknowledged before me by _____, the principal, and subscribed before me by _____ and _____, witnesses, on _____, 20____.

[Seal]

_____

Notary Public
My commission expires: _____