

**IDAHO**  
**A DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

**1. DESIGNATION OF HEALTH CARE AGENT**

I,

(Insert your name and address)

do hereby designate and appoint

(Insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider, (2) a nonrelative employee of your treating health care provider, (3) an operator of a community care facility, or (4) a nonrelative employee of an operator of a community care facility).

as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, “health care decision” means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual’s physical condition.

**2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.**

By this document I intend to create a durable POWER OF ATTORNEY for HEALTH CARE. This power of attorney shall not be affected by my subsequent incapacity.

**3. GENERAL STATEMENT OF AUTHORITY GRANTED.** Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures. (If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4 (“Statement of Desires, Special Provisions, and Limitations”) below. You can indicate your desires by including a statement of your desires in the same paragraph.)

**4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.** (Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. you should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable POWER of ATTORNEY for HEALTH CARE, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated in the living will. Additional statement of desires, special provisions, and limitations:

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign each of the additional pages at the same time you date and sign this document.)

**5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.** Subject to any limitations in this document, my agent has the power and authority to do all of the following:

- (a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to , medical and hospital records.
- (b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.
- (c) Consent to the disclosure of this information.
- (d) Consent to the donation of any of my organs for medical purposes. (If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 (“Statement of Desires, Special Provisions, and Limitations”))

**6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES.** Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

- (a) Documents titled or purporting to be a “Refusal to Permit Treatment” and “Leaving Hospital Against Medical Advice.”
- (b) Any necessary waiver or release from liability required by a hospital or physician.

**7. DESIGNATION OF ALTERNATE AGENTS.**

(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designate in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternate Agent

(Insert name, address, and telephone number of first alternate agent)

B. Second Alternate Agent

(Insert name, address, and telephone number of second alternate agent)

**8. PRIOR DESIGNATIONS REVOKED.** I revoke any prior durable Power of Attorney for Health Care.

**DATE AND SIGNATURE OF PRINCIPAL**

(You Must Date and Sign This Power of Attorney)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on \_\_\_\_\_ at \_\_\_\_\_, \_\_\_\_\_  
(Date) (City) (State)

\_\_\_\_\_  
(You sign here)

(This Power of Attorney will not be valid unless it is signed by two qualified witnesses who are present when you sign or acknowledge your signature. If you have attached any additional pages to this form, you must date and sign each of the additional pages at the same time you date and sign this Power of Attorney.)

**STATEMENT OF WITNESSES**

(This document must be witnessed by two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as your agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury under the laws of Idaho that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee or a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_ Residence address: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_ Residence address: \_\_\_\_\_

(At least one of the above witnesses must also sign)

I further declare under penalty of perjury under the laws of Idaho that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

### NOTARY

(Signer of instrument may either have it witnessed as above or have his/her signature notarized as below, to legalize this instrument.)

State of Idaho

County of \_\_\_\_\_ ss.

On this \_\_\_\_\_ day of \_\_\_\_\_ (year)

before me personally appeared \_\_\_\_\_  
(full name of signer of instrument)

to me known (or proved to me on basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he/she executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

\_\_\_\_\_  
(Signature of Notary)