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IOWA

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I hereby designate as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgement of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the law of this state, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to the provision of any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document.

My agent has the right to examine my medical records and to consent to disclosure of such records.

2. In addition to the foregoing, the principal may provide specific instructions in the document conferring the durable power of attorney for health care, consistent with the provisions of this chapter.

3. The principal may include a statement indicating that the designated attorney in fact has been notified of and consented to the designation.

4. A durable power of attorney for health care may designate one or more alternative attorneys in fact.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this durable power of attorney for health care on_____day of _____, _____(year)

at_____
(City and State)

_____
(Signature)

_____
(Print Name)

This product does not constitute the rendering of legal advice or services. This product is intended for informational use only and is not a substitute for legal advice. State laws vary, so consult an attorney on all legal matters. This product was not prepared by a person licensed to practice law in this state.

STATEMENT OF WITNESSES.

I declare under penalty of perjury that the principal has identified himself or herself to me, that the principal signed or acknowledged this durable power of attorney in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, that I am not a provider of health or residential care, an employee of a provider of health or residential care, the operator of a community care facility, or an employee of an operator of a health care facility.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness Signature:_____

Print Name:_____Date:_____

Address:_____

Witness Signature:_____

Print Name:_____Date:_____

Address:_____

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