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TENNESSEE

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document you should know these important facts.

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent: (1) authorizes anything that is illegal; or (2) acts contrary to your desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to: (1) authorize an autopsy; (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes; and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask an attorney to explain it to you.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DESIGNATION OF HEALTH CARE AGENT.

I, (insert your name) appoint:

Name:

Address:

Phone

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in the document. This durable power of attorney for health care takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

DESIGNATION OF ALTERNATE AGENT.
(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent
Name:
Address:
Phone:

B. Second Alternate Agent
Name:
Address:
Phone:

The original of this document is kept at

The following individuals or institutions have signed copies:
Name:
Address:

Name:
Address:

DURATION.
I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health

care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date:

PRIOR DESIGNATIONS REVOKED.
I revoke any prior durable power of attorney for health care.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT.
I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

(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)

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.
l 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:_____