DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS
GENERAL STATEMENT OF AUTHORITY GRANTED
K.S.A. 58-632

I, _____ , _____ , _____ , designate and appoint:
name | date of birth (optional) | last four digits of SSN (optional)

Name _____
Address _____
Telephone Number _____

to be my agent for healthcare decisions and pursuant to the language stated below, on my behalf to:

(1) Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, and to make decisions about organ donation, autopsy and disposition of the body;

(2) make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge healthcare personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer healthcare as the agent shall deem necessary for my physical, mental and emotional well-being; and

(3) request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute any releases of other documents that may be required in order to obtain such information.

In exercising the grant of authority set forth above my agent for healthcare decisions shall:

(Here may be inserted any special instructions or statement of the principal's desires to be followed by the agent in exercising the authority granted).

LIMITATIONS OF AUTHORITY

(1) The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for healthcare decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.

(2) The agent shall be prohibited from authorizing consent for the following items:

(3) This durable power of attorney for healthcare decisions shall be subject to the additional following limitations:

EFFECTIVE TIME

This power of attorney for healthcare decisions shall become effective *(immediately and shall not be affected by my subsequent disability or incapacity or upon the occurrence of my disability or incapacity).*

REVOCATION

Any durable power of attorney for healthcare decisions I have previously made is hereby revoked.
(This durable power of attorney for healthcare decisions shall be revoked *by an instrument in writing executed, witnessed or acknowledged in the same manner as required herein or set out another manner of revocation, if desired*.)

EXECUTION

Executed this _____ , at _____ , Kansas.

_____ Principal.

This document must be: (1) Witnessed by two individuals of lawful age who are not the agent, not related to the principal by blood, marriage or adoption, not entitled to any portion of principal's estate and not financially responsible for principal's healthcare; OR (2) acknowledged by a notary public.

_____ _____
Witness Witness

_____ _____
Address Address

(OR)

STATE OF _____)
SS.
COUNTY OF _____)

This instrument was acknowledged before me on _____ by _____
date name of person

_____
Signature of notary public

(Seal, if any)

My appointment expires: _____

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1. I hereby authorize _____ to use and/or disclose the protected
   name of healthcare provider
   health information described below to _____ .
   name of individual

2. Authorization for Release of Information. Covering the period of healthcare from

   ☐ _____ to _____ **OR** ☐ all past, present, and future periods:

3. ☐ I hereby **authorize the release of my complete health record** (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

   OR

   ☐ I hereby **authorize the release of my complete health record with the exception of the following information**:

   - ☐ Mental health records
   - ☐ Communicable diseases (including HIV and AIDS)
   - ☐ Alcohol/drug abuse treatment
   - ☐ Other (please specify):_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ , at which time this authorization expires.
   date or event

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative	Date
Print Name of Patient or Personal Representative	Relationship to Patient

LIVING WILL DECLARATION

K.S.A. 65-28,103

Declaration made this ____ day of _____ (month, year). I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.
I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

City, County and State of Residence _____

Date of Birth (optional) _____

Last four digits of SSN (optional) _____

The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care.

Witness _____ Witness _____

(OR)

STATE OF _____)
SS.
COUNTY OF _____)

This instrument was acknowledged before me on _____ by _____
date name of person

_____
Signature of notary public

(Seal, if any)

My appointment expires: _____

PRE-HOSPITAL DNR REQUEST FORM
AN ADVANCED REQUEST TO LIMIT THE SCOPE OF EMERGENCY MEDICAL CARE

K.S.A. 65-4942

I, _____ , _____ , _____ , request limited emergency care as herein described.
name | date of birth (optional) | last four digits of SSN (optional)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will *not* prevent me from obtaining other emergency medical care by pre-hospital care providers or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time.

I give my permission for this information to be given to the pre-hospital care providers, doctors, nurses, or other healthcare personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) directive.

_____ _____
Signature Date

_____ _____
Witness Date

I AFFIRM THIS DIRECTIVE IS THE EXPRESSED WISH OF THE PATIENT, IS MEDICALLY APPROPRIATE, AND IS DOCUMENTED IN THE PATIENT'S PERMANENT MEDICAL RECORD.

In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation will be initiated.

_____ _____
Attending Physician's Signature Date

_____ _____
Address Facility or Agency Name

* Signature of physician not required if the above-named is a member of a church or religion which, in lieu of medical care and treatment, provides treatment by spiritual means through prayer alone and care consistent therewith in accordance with the tenets and practices of such church or religion.

REVOCATION PROVISION

I hereby revoke the above declaration.

_____ _____
Signature Date

WALLET CARDS

I HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE	A copy of my document can be found in these places:
My Name: _____	
My Healthcare Agent: _____	
My Agent's Phone #: _____	Other copies of my document are held by:
My Doctor: _____	Name: _____ Phone: _____
My Doctor's Phone #: _____	Name: _____ Phone: _____

I HAVE A LIVING WILL	A copy of my document can be found in these places:
My Name: _____	
My Doctor: _____	
My Doctor's Phone #: _____	
I ALSO HAVE A HEALTHCARE AGENT (DURBALE POWER OF ATTORNEY)	Other copies of my document are held by:
My Healthcare Agent: _____	Name: _____ Phone: _____
My Agent's Phone #: _____	Name: _____ Phone: _____

I HAVE A DO NOT RESUSCITATE DIRECTIVE (DNR)	A copy of my document can be found in these places:
My Name: _____	
My Doctor: _____	
My Doctor's Phone #: _____	
I ALSO HAVE A HEALTHCARE AGENT (DURBALE POWER OF ATTORNEY)	Other copies of my document are held by:
My Healthcare Agent: _____	Name: _____ Phone: _____
My Agent's Phone #: _____	Name: _____ Phone: _____