**LOUISIANA**

**HEALTH CARE POWER OF ATTORNEY**

**1.** I, _____, hereby appoint:

| | |
|---|---|
| _____ | _____ |
| Name | Home Address |
| (_____)_____ | _____ |
| Home Telephone Number | |
| (_____)_____ | (_____)_____ |
| Work Telephone Number | Cell Telephone Number |

as my agent to make health-care decisions for me if I become unable to make my own health-care decisions, as follows (initial one choice per option):

**A.** _____ I DO/ _____ I DO NOT grant my agent the power to: Grant, refuse, or withdraw consent on my behalf for any health care service, treatment or procedure, even though my death may ensue.

**B.** _____ I DO/ _____ I DO NOT grant my agent the power to: Authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service.

**C.** _____ I DO/ _____ I DO NOT grant my agent the power to: Contract on my behalf for any health-care related services or facility (without my agent incurring personal financial liability for such contracts) such as surgery, medical expenses and prescriptions.

**D.** _____ I DO/ _____ I DO NOT grant my agent the power to: Make decisions regarding surgery, medical expenses and prescriptions.

**E.** _____ I DO/ _____ I DO NOT grant my agent the power to: Prevent or limit reasonable communication, visitation, or interaction between me and a relative by blood, adoption or marriage, or another individual who has a relationship based on strong affection, specifically the following individuals:
_____, _____, or _____. The following individuals shall not be restricted from reasonable communication, visitation, or interaction with me.
_____, _____, or _____

**2.** If the person named as my agent is not available or is unable to act as my agent, I appoint the following person(s) to serve in the order listed below:

**A.**

_____ _____
Name Home Address

(_____)_____ _____
Home Telephone Number

(_____)_____ (_____)_____
Work Telephone Number Cell Telephone Number

**B.**

_____ _____
Name Home Address

(_____)_____ _____
Home Telephone Number

(_____)_____ (_____)_____
Work Telephone Number Cell Telephone Number

**3.** With this document, I authorize any person, organization, or entity involved with my health care to disclose and release to my agent any and all of my individually identifiable health information and medical records in accordance with HIPAA. I further authorize my agent to talk to health care personnel, get information, have access to medical records and sign forms necessary to carry out these decisions.

**4. SPECIAL PROVISIONS AND LIMITATIONS.**

I do NOT want the following treatments:
1._____
2._____
3._____
4._____

I DO want the following treatments:
1._____
2. _____
3._____
4._____

Other provisions and limitations:
_____
_____

**5.** No person who relies in good faith upon representations by my agent or alternate agent shall be liable to me, my estate, my heirs or assigns for recognizing the agent's authority.

**6.** The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect any others.

**BY MY SIGNATURE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.**

I SIGN MY NAME TO THIS FORM ON _____, 20__.

at: _____.
(City, State)

_____
(Signature)

**WITNESSES**

The person who signed or acknowledged this document is personally known to me and I believe him/her to be of sound mind.

First Witness Signature: _____

Print Witness Name _____Date: _____

Second Witness Signature: _____

Print Witness Name: _____ Date: _____

NOTARIZATION (Optional)

STATE OF _____ PARISH OF _____

I, _____, a Notary Public in and for the State and Parish aforesaid, do hereby certify that _____, who personally came and appeared before me as the Principal, and executed the foregoing Durable Power of Attorney for Health-Care in said State and Parish, and acknowledged said Durable Power of Attorney for Health-Care as the Principal's voluntary act.

Witness my signature this _____ day of _____, 20__.

_____
NOTARY PUBLIC