Medical Power of Attorney

State of Rhode Island

Date:

1. Appointment of a Health Care Agent

I, _____, the Principal, living at the primary Address of _____, City of _____, State of _____, hereby appoint, _____, the Agent, living at the primary Address of _____, City of _____, State of _____ as my Agent to act as set forth below, in my name to make any and all medical decisions on my behalf unless I limit those decisions in this document. This Medical Power of Attorney takes effect only when my Doctor certifies in writing that I can no longer make my own health care decisions. My Agent can be contacted on the following:

Mobile Number: _____

Home Phone Number: _____

Email: _____

Address: _____

2. My Agent's Powers

My Agent understands my wishes from conversations and any other guidance I may have written and signed. My Agent has complete authority to make decision on my behalf in regard to my health care according to my wishes. If my wishes are unclear, then I grant my Agent power to decide what they believe to be in my best interests. My Agent's power is to be interpreted from my wishes as broadly as possible and includes the following authority which I have designated with my initials (This is only to be applicable if initialed).

(a) ____-To refuse, agree or withdraw consent to any type of medical care, surgical procedures, treatment, medications or tests. This includes decisions in regard to any procedure that affects my bodily functions such as artificial respiration, hydration, artificial respiration, cardiopulmonary resuscitation, and any other form of medical support, even if the refusal or withdrawal of treatment could or would result in my death.

(b) ____-To have access to all my medical records and information to the same extent as I am entitled to, including the right to disclose health information to others.

(c) ____-To hire and fire any medical, social service, and other support personnel who are responsible for my care.

(d) ____-To refuse or to agree to using any medication or procedure intended to relieve pain or discomfort, even though that use may lead to physical damage or dependence or accelerate (unintentionally) my death.

(e) ____-To contract for any health care-related service or facility for me, or apply for private or public health care benefits, with the understanding that my agent is not personally financially responsible for those contracts.

(f) ____-To authorize my admission to or discharge from any hospital, nursing home, residential care, assisted-living or similar facility or service.

(g) ____-To decide about organ and tissue donations, autopsy, and the disposition of my remains as the law permits.

(h) ____-To authorize my participation in medical research related to my medical condition.

(i) ____-To take any other action necessary to do what I authorize here, including signing waivers or other documents, pursuing any dispute resolution process, or taking legal action in my name.

3. Special Instructions and Limitations for My Agent

4. Alternative Agents

If my Agent appointed above is unable or unwilling to serve as my Agent, I appoint the following person(s) to serve as Agents in the order set out below with the authority to make health care decision on my behalf as provided herein:

4.1. First Alternate Agent

Name: _____

Phone: _____

Address:_____

4.2. Second Alternate Agent

Name: _____

Phone: _____

Address:_____

5. Original and Copies of This Document

The original document will be filed

_____

A copy of this document will be filed

---

6. Duration

Unless stated otherwise, this Medical Power of Attorney shall remain in effect until I revoke it. I understand that I cannot revoke this document during the time I am considered incompetent to make my own decisions.

(This is only to be applicable if initialed).

____-This Medical Power of Attorney shall expire on _____ day of _____, 20___.

7. Notary Public

NOTARY ACKNOWLEDGMENT

State of Rhode Island, _____ County, ss. On this _____ day of _____, 20__, the foregoing document was acknowledged by _____, as Maker of this Medical Power of Attorney who proved they are the above-named person through government issued photo identification, and in my presence (s)he executed the foregoing instrument and acknowledged that (s)he executed the same as his/her free act and deed.

_____
Notary Public

_____
Print Name

Commission Expiry Date: _____

OR

8. Witnesses

Witness Statement and Acknowledgment

I am not related to the Maker of this document by blood or marriage. I am not the person appointed as the Agent or Successor Agent in this Medical Power of Attorney. I am not involved in providing direct patient care to the Maker and I am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility. I do not have any claims against the Maker's estate, nor am I entitled to any portion of the Maker's estate. I am not the attending physician of the Maker or an employee of the attending physician.

8.1. Signature of the first witness

_____
SIGNATURE

_____
PRINT NAME

DATE: _____

ADDRESS:_____

8.2. Signature of the second witness

_____
SIGNATURE

_____
PRINT NAME

DATE: _____

ADDRESS:_____