OCHSNER HEALTH SYSTEM
ADVANCE DIRECTIVE

POWER OF ATTORNEY FOR
HEALTH CARE DECISIONS

The Person I Want To Make Health Care Decisions For Me When I Cannot Make Them For Myself

If I, _____, being of sound mind, am no longer able to make my own health care decisions, the person I choose as my Health Care Power of Attorney is:

(First Choice Name) _____

(Address) _____(Phone Number) _____

If this person is not able or willing to make these choices for me, OR is divorced or legally separated from me, OR this person has died, then these people are my next choices:

(Second Choice Name) _____**(Third Choice Name)** _____

(Address) _____(Address) _____

(City/State/Zip) _____(City/State/Zip) _____

(Phone) _____(Phone) _____

I understand that my Health Care Power of Attorney can make health care decisions for me. I want my Health Care Power of Attorney to be able to do the following:
Please cross out/strike through all items that you do NOT want your agent/attorney in fact to do.

make health care and treatment decisions for me
make decisions concerning surgery
make decisions concerning medical expenses
make decisions concerning hospitalization
make decisions concerning nursing home residency
take any legal action needed to carry out my wishes
make decisions concerning the withholding or withdrawal of life sustaining procedures
make decisions concerning medications
see and approve the release of my medical record
make decisions concerning selection of physicians
apply for Medicare/Medicaid or other programs for insurance

Such Health Care Power of Attorney has full authority to make such decisions as fully, completely and effectually, and to all intents and purposes with the same validity as if such decisions had been personally made by me.

This Health Care Power of Attorney is effective immediately and serves to revoke and supersede any prior Health Care Power of Attorney I have previously executed. This Health Care Power of Attorney will continue until it is revoked.

This declaration is made and signed by me on this _____ day of _____, in the year _____, in the presence of the undersigned witnesses who are not entitled to any portion of my estate.

Signed: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

WITNESS ACKNOWLEDGEMENT: The Declarant is and has personally been known to me, and I believe the Declarant to be of sound mind. I am not related to the Declarant by blood or marriage and would not be entitled to any portion of Declarant's estate upon his/her death. I was physically present and personally witnessed the Declarant execute the foregoing Declaration.

_____ WITNESS SIGNATURE / Print Witness Name / Date / Time

_____ WITNESS SIGNATURE / Print Witness Name / Date / Time