

**MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS**

**I. APPOINTMENT OF AGENT AND ALTERNATES**

I, \_\_\_\_\_ ,  
Declarant, hereby appoint:

\_\_\_\_\_  
*Name of Agent*

\_\_\_\_\_  
*Agent's Best Contact Telephone Number*

\_\_\_\_\_  
*Agent's email or alternative telephone number*

\_\_\_\_\_  
*Agent's home address*

as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, or refuse, or stop any healthcare, treatment, service, or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed below.

\_\_\_\_\_  
*Name of Alternate Agent #1*

\_\_\_\_\_  
*Agent's Best Contact Telephone Number*

\_\_\_\_\_  
*Agent's email or alternative telephone number*

\_\_\_\_\_  
*Agent's home address*

\_\_\_\_\_  
*Name of Alternate Agent #2*

\_\_\_\_\_  
*Agent's Best Contact Telephone Number*

\_\_\_\_\_  
*Agent's email or alternative telephone number*

\_\_\_\_\_  
*Agent's home address*

**II. WHEN AGENT'S POWERS BEGIN**

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect either (*initial one*):

\_\_\_\_\_ (*Initials*) Immediately upon my signature.

\_\_\_\_\_ (*Initials*) When my physician or other qualified medical professional has determined that I am unable to make my or express my own decisions, and for as long as I am unable to make or express my own decisions.

**III. INSTRUCTIONS TO AGENT**

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines is in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

*State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

My signature below indicates that I understand the purpose and effect of this document:

\_\_\_\_\_  
*Signature of Declarant* \_\_\_\_\_  
*Date*

**ADDENDUM TO MEDICAL DURABLE POWER OF ATTORNEY – RECOMMENDED, NOT REQUIRED**

**1. Signature of the Appointed Agent**

Although not required by Colorado law, my signature below indicates that I have been informed of my appointment as a Healthcare Agent under Medical Durable Power of Attorney for *(name of Declarant)*

\_\_\_\_\_

I accept the responsibilities of that appointment, and I have discussed with the Declarant his or her wishes and preferences for medical care in the event that he or she cannot speak for him- or herself.

I understand that I am always to act in accordance with his or her wishes, not my own, and that I have full authority to speak with his or her healthcare providers, examine healthcare records, and sign documents in order to carry out those wishes. I also understand that my authority as a Healthcare Agent is only in effect when the Declarant is unable to make his or her own decisions and that it automatically expires at his or her death.

If I am an alternate Agent, I understand that my responsibilities and powers will only take effect if the primary Agent is unable or unwilling to serve.

\_\_\_\_\_  
*Primary Agent's Signature*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Alternate Agent #1 Signature*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Alternate Agent #2 Signature*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Date*

**2. Signature of Witnesses and Notary**

The signature of two witnesses and a notary seal are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed by *(name of Declarant)*  
\_\_\_\_\_

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We declare that, at the time the Declarant signed this document, we believe that he or she was of sound mind and under no pressure or undue influence. We are at least eighteen (18) years old.

\_\_\_\_\_  
*Signature of Witness*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*Signature of Witness*

\_\_\_\_\_  
*Printed Name*

\_\_\_\_\_  
*Address*

**Notary Seal (optional)**

State of \_\_\_\_\_

County of \_\_\_\_\_ }

SUBSCRIBED and sworn to before me by

\_\_\_\_\_, the Declarant,

and \_\_\_\_\_

and \_\_\_\_\_

witnesses, as the voluntary act and deed of the Declarant

this day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

My commission expires: \_\_\_\_\_