COLORADO ADVANCE DIRECTIVE
Medical Durable Power of Attorney and Declaration as to Medical or Surgical Treatment

Being of sound mind, I appoint the below Agents and make this Declaration for use at any future time when I am not able to participate in necessary medical decisions. This document supersedes all previous Advance Directive signed by me.

This document shall be governed by the laws of the State of Colorado in all respects, including its validity, construction, interpretation, and termination. However, I intend for this document to be honored in any jurisdiction in which it may be presented and for any such jurisdiction to refer to Colorado law to interpret and determine the validity of this document and any of the powers granted under this document.

Photocopies of this document shall be as effective as the original. I specifically direct my Agent to have photocopies of this document placed in my medical records.

Part One: Medical Durable Power of Attorney

I, _____,
Print name

of _____,
Address

hereby appoint, to serve as my Agent and to exercise the powers set forth below:

_____
Print name, address, phone and email

_____

I, the undersigned, accept appointment as Agent under this Medical Durable Power of Attorney and Directive for Medical or Surgical Treatment.

_____,
Print name

_____,
Signature

If my Primary Agent is not available, or unable or unwilling to serve, I hereby designate as my First Alternate Agent:

_____
Print name, address, phone and email

_____

I, the undersigned, accept appointment as Alternate Agent under this Medical Durable Power of Attorney and Directive for Medical or Surgical Treatment.

_____,
Print name

_____,
Signature

If my Primary and First Alternate Agent are not available, or unable or unwilling to serve, I designate as my Second Alternate Agent:

_____
Print name, address, phone and email

I, the undersigned, accept appointment as Alternate Agent under this Medical Durable Power of Attorney and Directive for Medical or Surgical Treatment.

_____,
Print name

_____,
Signature

ACTIVE DATE AND DURABILITY

This Medical Durable Power of Attorney shall be effective upon, and only during, any period of disability or incapacity in which, in the opinion of my attending healthcare professional, I am unable to make or communicate responsible decisions regarding medical treatment or healthcare for myself.

AGENT'S AND ALTERNATE AGENTS' POWERS

I grant to my Agent and Alternate Agent(s) full authority to make decisions for me regarding medical and psychological treatment. In exercising this authority, my Agents shall follow my desires as stated in my Declaration as to medical or surgical treatment. In making decisions, my Agents shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate rationally.

If my Agents cannot determine the choice I would want made, then my Agents shall make a choice for me based upon what my Agents believe to be in my best interest. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below. Accordingly, my Agents are authorized as follows:

- To consent to, refuse, or withdraw consent to, any and all types of medical and psychiatric care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect bodily function, including (but not limited to) artificial respiration, artificial nourishment and hydration, and cardiopulmonary resuscitation.

- To take any other action necessary to implement my preferences as expressed herein or elsewhere, including (but not limited to) granting any waiver or release from liability required by any hospital, healthcare professional, or other healthcare provider; signing any documents relating to acceptance or refusal of treatment or discharge from a facility against medical advice; and pursuing any legal action in my name, and at my own or my estate's expense, to enforce compliance with my wishes as determined by my Agent, including claims for actual or punitive damages for any such failure to comply.

- To have access to my medical records and information to the same extent that I am entitled, including the right to disclose the contents to others as appropriate.

- To authorize my admission to or discharge from any hospital, long term care facility, assisted living, or similar care facility or service.

- To contract on my behalf for any healthcare related service or facility, without my Agent's incurring personal financial liability for such contracts.

- To retain and discharge medical, hospice, social service and other support personnel responsible for my care.

- To make anatomical gifts upon my death as follows. *(Initial those that apply)*

  - _____ Organ, tissue, and/or bone donations for the limited purpose of transplantation to such persons or organizations as my agent shall deem appropriate, and to execute such papers and do such acts as shall be necessary and appropriate with such gifts.

  - _____ Anatomical gifts (full body) for the purpose of medical research to such persons and organizations as my agent shall deem appropriate, and to execute such papers and do such acts as shall be necessary and appropriate in connection with such gifts.

  - _____ I do NOT authorize my agents to make any anatomical gifts on my behalf.

- To follow my instructions for: *(Initial those that apply)*

  _____ Cremation _____ Burial
  _____ Funeral _____ Memorial Service _____ Other

  I have prearranged my cremation or burial. The papers are located: _____

  _____

ACCESS TO MEDICAL RECORDS AND OTHER PERSONAL INFORMATION

My Agents shall have the power to request, receive, review and release any information, including medical and hospital records, drug-and-alcohol treatment information, mental health information, and other data having special protections under the law, specifically including the Health Insurance Portability and Authorization Act of 1996 (HIPAA), regarding my physical or mental health; to execute any releases, waivers, insurance forms, or other documents that may be requested in order to obtain such information; or to obtain government assistance or insurance payment for any service rendered to me or for my benefit. Each person nominated to be my Agent shall specifically be authorized to receive all personal health information and documents necessary to determine my incapacity as if such persons were already acting as my Agent.

GRANTING RELEASES

My Agents, on behalf of me, my heirs, and my estate, shall have the power to grant waivers or releases from liability to healthcare providers and other persons or covered entities (as defined under HIPAA) involved in providing healthcare services for me or maintaining my protected health information and other healthcare records, who act in reliance on instructions given by my Agents for the purpose of carrying out the provisions of this document.

NOMINATION OF GUARDIAN

If a guardian should need to be appointed, I nominate my Agent, or an Alternate Agent named above, if my Agent is unable or unwilling to serve.

Part Two. Declaration as to Medical or Surgical Treatment (Living Will)

1. If I have a **TERMINAL INJURY, ILLNESS OR DISEASE**, or am or will be in a **PROLONGED and/or IRREVERSIBLE COMA**, or am in a **PERSISTENT VEGETATIVE STATE**; or am in an **ADVANCED STAGE OF PROGRESSIVE DEMENTIA**; and if my healthcare professionals certify that there is no reasonable probability of recovery from these conditions; I direct that the procedures I have initialed be initiated and continued (initial "Yes"); initiated, but discontinued if not effective (Initial "Trial"); or withheld or withdrawn (initial "No"). ***I am aware that withholding or withdrawing any of these procedures may hasten my death.***

	Yes	Trial*	No
Cardiopulmonary resuscitation (CPR)			
No life sustaining treatments – comfort care only			
Medication to control pain			
No hospitalization			
Hospitalization for infection			
Antibiotics to treat infection at home			
Hospitalization in intensive care			
Surgery to control pain			
Invasive diagnostic tests or procedures			
Heart-regulating drugs for irregular heartbeat			
Pacemaker to regulate heartbeat			
Oxygen support for breathing			
Artificial breathing (respirator)			
Blood transfusion			
Chemotherapy			
Kidney dialysis			
Hospice care at _____home, _____care facility or _____hospice facility			
Other:			

**A trial period means that doctors will see if a therapy quickly reverses my condition. If it does not, I want it discontinued.*

2. Specifically with regard to NOURISHMENT AND HYDRATION, I have initialed the following items with which I agree:

If I am unconscious and my healthcare providers have established that there is no reasonable likelihood that I will ever return to a conscious state, **or** if I have advanced progressive dementia and am no longer able to feed myself, I declare my wishes to:

_____be offered spoon feeding, but never be fed forcefully

_____stop eating and drinking by mouth

_____accept _____intravenous or _____tube feeding for ____nutrition and/or ____hydration

_____refuse _____intravenous or _____tube feeding for ____nutrition and/or ____hydration

Other instructions:

_____
_____
_____
_____
_____
_____
_____

Part Three. Exculpation, Revocation, Resignation and Severability

EXCULPATION

A. My Agent and my Agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, heirs, successors, and assigns from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my Agent. No person who relies in good faith upon any representations by my Agent or Alternate Agents shall be liable to me, my estate, my heirs or my successors or assigns for recognizing the Agent's authority.

B. Any healthcare professional or other individual acting on my behalf is authorized and directed to follow these instructions. No healthcare professional signing a certificate of terminal condition and no healthcare professional, hospital or hospital personnel withholding or withdrawing life-sustaining procedures in compliance with this declaration, in the absence of actual knowledge of revocation or fraud, misrepresentation, or improper execution, shall be subject to civil liability, criminal penalty, or licensing sanctions therefore. On behalf of myself, my Agents, my family and my heirs and devisees, I hereby release any person who acts in reliance on the foregoing sentence from any claim or liability for any injury to me or arising by reason of my death.

REVOCATION AND RESIGNATION

I reserve the right to revoke or amend this document and to substitute other Agents in place of those designated herein while I am mentally competent. Amendments or revocation shall only be made in writing by me personally, and shall replace the original and all copies of this document.

My agent and any Alternate Agent may resign by the execution of a written resignation delivered to me, or, if I am mentally incapacitated, by delivery to any person in charge of my care and custody.

SEVERABILITY

If any part of any provision of this document shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity only, without in any way affecting the remaining provisions of this document.

SIGNATURES

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT. I AM OF SOUND MIND AND KNOWINGLY AND WILLFULLY EXECUTE THIS DOCUMENT.

I sign my name to this Medical Durable Power of Attorney and Declaration as to Medical or Surgical Treatment on this _____ day of _____, 20_____

Signature _____

Home address _____

WITNESSES' STATEMENT

I do hereby declare that the Principal (the person who has signed or acknowledged this document), _____, has signed or acknowledged this Medical Durable Power of Attorney and Declaration as to Medical / Surgical Treatment Document in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

To the best of my knowledge, I am not a creditor of the Principal nor entitled to any part of his or her estate under a will now existing or by operation of law.

Witness No. 1

Signature: _____Date: _____

_____
Print name, address, phone and email

_____

Witness No. 2

Signature: _____Date: _____

_____
Print name, address, phone and email

_____

Notarizing is optional. If you wish to have this document notarized, use the following form:

STATE OF COLORADO

CITY _____ COUNTY _____

Subscribed and sworn to before me by _____,

(the Principal), as a voluntary act, this _____ day of_____, 20_____.

Notary Public _____

Stamp: