I appoint ____________________________________REPRESENTATIVE, who currently resides at

____ ADDRESS, and who can be reached at the following

telephone numbers: ______________________(home) ______________________(work), as my Health

Care Representative who is authorized to act for me in all matters affecting my health care in accordance with

Indiana Code 16-8-12, et seq., at any time I am unable to make health care decisions for myself.

This authority includes, but is not limited to the following:

1. To employ or discharge servants, companions, nurses or doctors to care for me;
2. To admit me to, or release me from, any hospital, nursing home or health care facility;
3. To access any of my medical records.

Further, I authorize my Health Care Representative to make decisions in my best interest concerning withdrawal or withholding of health care, including but not limited to the provision of artificial nutrition and hydration. If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my Health Care Representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my Health Care Representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My Health Care Representative must try to discuss this decision with me. However, if I am unable to communicate, my Health Care Representative may make such a decision for me, after consultation with my physician or physicians and other relevant caregivers. To the extent appropriate, my Health Care Representative may also discuss this decision with my family and others; to the extent they are available.

I authorize my Health Care Representative to delegate all or part of this authority to any eligible individual who has not been disqualified as provided by Indiana Code 16-8-12, et seq. This appointment shall not be affected by my subsequent disability or incapacity or by lapse of time.

DATED this ________ day of ______________________________, 20________.

SIGNATURE: ____DATE OF BIRTH:________________

PRINTED NAME: ____

ADDRESS: ____

____

I declare that, at the request of the above named individual making the appointment, I witnessed the signing of this document.

SIGNATURE: ____

PRINTED NAME: ____

ADDRESS: ____

____

Reid Health
Richmond, IN 47374 (765) 983-3000

Room:______

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

PATIENT LABEL