

**KANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DECISIONS GENERAL STATEMENT OF AUTHORITY GRANTED**

I, _____,
(name)

designate and appoint: _____
(name of proxy)

(address)

(home telephone number)

(work telephone number)

or, in the event the person I appoint above is unable, unwilling or unavailable to serve, I appoint:

(name of alternate proxy)

(address)

(home telephone number)

(work telephone number)

to be my proxy for health care decisions and pursuant to the language stated below, on my behalf to:

- (1) Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, and to make decisions about organ donation, autopsy and disposition of the body;
- (2) make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge health care personnel, to include physicians, psychiatrists, psychologists, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care, as the proxy shall deem necessary for my physical, mental and emotional well being; and
- (3) request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health, including medical and hospital records, and to execute any releases of other documents that may be required in order to obtain such information.

In exercising the grant of authority set forth above my proxy for health care decisions shall: (Here may be inserted any special instructions or statement of the principal's desires to be followed by the proxy in exercising the authority granted)

LIMITATION OF AUTHORITY

(1) The powers of the proxy herein shall be limited to the extent set out in writing in this durable power of attorney for health care decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.

(2) The proxy shall be prohibited from authorizing consent for the following items:

(3) This durable power of attorney for health care decisions shall be subject to the additional following limitations:

EFFECTIVE TIME

This power of attorney for health care decisions shall become effective upon my disability or incapacity.

REVOCATION

Any durable power of attorney for health care decisions I have previously made is hereby revoked.

EXECUTION

Executed this _____, at _____, Kansas.
(date) (county)

(principal)

This document must be: (1) Witnessed by two individuals of lawful age who are not the proxy, not related to the principal by blood, marriage or adoption, not entitled to any portion of the principal's estate and not financially responsible for the principal's health care; OR (2) acknowledged by a notary public.

Witness _____

Address _____

Witness _____

Address _____

OR

STATE OF KANSAS)

SS.

COUNTY OF)

This instrument was acknowledged before me on

(date)

by _____
(name of principal)

(signature of notary public)

(Seal, if any)

My appointment expires: _____