Durable Power of Attorney for Health Care

I understand that it is my right to control all aspects of my personal and medical treatment. However, if I become incapacitated and unable to make my own decisions, then I appoint _____ as my agent with rights to make any and all health care decisions for me. This person's decisions shall be valid to the extent that the same decisions would be valid if I made them myself and shall have access to all records and materials needed to make those decisions. I understand that the decisions of this person shall take precedent over all others except myself. The powers of this declaration shall be valid even if I become disabled, incapacitated, or incompetent.

If the agent listed as (1) above is unable or unwilling to perform his duties as my health care power of attorney, then I name

_____ as successor with the same rights and powers.

If both (1) and (2) as listed above are unable or unwilling to perform his duties as my health care power of attorney, then I name

_____ as successor with the same rights and powers.

This declaration is made pursuant to A.C.A. 20-13-104, but shall be considered valid regardless of the validity or continuation of that Act.

_____ _____

Signed Date

_____ _____

Witness Address

_____ _____

Witness Address