Medical Durable Power of Attorney

I, ________________________________, principal, an adult of sound mind, execute this Medical Durable Power of Attorney pursuant to §§ 15-14-503 to 15-14-509, Colorado Revised Statutes, freely and voluntarily, with an understanding of its purposes and consequences. I intend my statements in this document to constitute clear and convincing evidence of my wishes concerning medical treatment.

Designation of Agent and Successor Agent(s)

I appoint:

____
(Name of Agent)

____
(Agent's Address)

____
(Agent's Home Phone Number) (Agent's Work Phone Number)

as my agent to make and communicate health care decisions for me as authorized in this document. This document, subject to any limitations described below, gives my agent the power to consent to, to refuse, or stop any healthcare treatment, service, or diagnostic procedure. My agent also has the authority to talk with healthcare personnel, get information, access my medical records, and sign forms necessary to carry out those decisions.

If the person named as my agent is unavailable, unable or unwilling to act as my agent, then I appoint the following person(s) to act as my successor agent in the order listed below:

1. ______________________________
(Name of Successor Agent)

____
(Successor Agent's Address)

____
(Successor Agent's Best Contact Tele. #)

2. ______________________________
(Name of Successor Agent)

____
(Successor Agent's Address)

____
(Successor Agent's Best Contact Tele. #)

Effective Date and Durability

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect and remain in effect despite a determination of my incapacity (*initial one*):

______ (*Initials*) immediately upon my signature.

______ (*Initials*) when my physician or other qualified medical professional has determined that I am unable to make or express my own decisions, and for long as I am unable to make or express my own decisions. I authorize medical professionals to release my medical records to my agent before such a determination is made so that my agent may work with medical professionsto determine whether I am unable to make or express my own decisions.

Agent's Authority

In making any decision, my agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate them in any way. If I am unable to communicate my desires, my agent should think about what action would be consistent with past conversations we have had, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, my agent shall base his/her decision on what he/she, in consultation with my healthcare providers, determines is in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options. My agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

My agent is specifically authorized:

a) to consent to, refuse, or withdraw consent to any and all types of psychiatric and medical 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 (CPR);

b) 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;

c) to admit or discharge me from any hospital, nursing home, residential care, assisted living, or similar care facility or service;

d) to contract on my behalf for any healthcare-related service or facility without my agent incurring personal financial liability for such contracts;

e) to retain and discharge medical, social service, and other support personnel responsible for my care; and

f) to take any other action necessary to implement my preference as to my healthcare 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 a refusal of treatment or the discharge from a facility against medical advice; and pursuing any legal action in my name and at my expense to force compliance with my wishes as determined by my agent, including claims for actual or punitive damages for any such failure to comply.

Limitations and Additional Instructions

The powers granted in this document are subject to the following rules, limitations, and additional instructions:

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Miscellaneous Provisions

I revoke any prior medical power of attorney executed by me. I intend this power of attorney to be valid in any jurisdiction where it is presented.

Signature

By signing below, I declare that I understand the purpose and effect of this document:

________________________________ _______________________

Signature of Principal Date

Witnesses (Optional)

We, ____________________ and ____________________, the witnesses, sign our names to this instrument, being first duly sworn, and do hereby declare to the undersigned authority that ____________________ (the principal) signs and executes this instrument and that he/she signs it willingly (or willingly directs another to sign for him/her) and that he/she executes it as his/her free and voluntary act for the purposes therein expressed.

____________________________ ____________________________
Witness Signature Witness Signature

Notarization (Optional)

STATE OF COLORADO)
) ss.
COUNTY OF____________)

SUBSCRIBED and acknowledged before me by ____________________________, the principal,

and subscribed before me by____________________________ and

____________________________, witnesses on this _______ day of __________ 2022.

Seal:

____
(Signature of Notarial Officer)

My commission expires: ______________