HEALTH CARE POWER OF ATTORNEY

Statutory Long Form

1. **Health Care Power of Attorney**

I, ____________________, as principal, designate ____________________, as my agent for all matters relating to my health care, including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint ____________________ as my agent.

I have _____ I have not _____ completed and attached a living will for purposes of providing specific direction to my agent in situations that may occur during any period when I am unable to make or communicate health care decisions or after my death. My agent is directed to implement those choices I have initialed in the living will.

I have _____ I have not _____ completed a prehospital medical care directive pursuant to Section 36-3251, Arizona Revised Statutes.

This health care directive is made under Section 36-3221, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

2. **Autopsy** (Under Arizona law an autopsy may be required.)

If you wish to do so, reflect your desires below:

_______ 1. **I do not** consent to an autopsy.

_______ 2. **I consent** to an autopsy.

_______ 3. My agent **may** give consent to **or refuse** an autopsy.

3. **Organ Donation** (Optional)

(Under Arizona law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental evaluation or research or for the advancement of medical or dental science. You may also authorize your agent to do so or a member of your family may make a gift unless you give them notice that you do not want a gift made. In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of a part of your body pursuant to law.) The donation elections you make in this health care Power of Attorney survive your death.

If any of the statements below reflects your desire, initial on the line next to that statement. **You do not have to initial any of the statements.**

If you do not check any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Arizona law.

_______ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_______ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution: ____________________

_______ Pursuant to Arizona law, I hereby give, effective on my death:

[ ] Any needed organ or parts.

[ ] The following part or organs listed:

____________________ ____________________ ____________________

For (check one):

[ ] Any legally authorized purpose.

[ ] Transplant or therapeutic purposes only.

4. **Physician Affidavit** (Optional)

(Before initialing any choices above you may wish to ask questions of your physician regarding a particular treatment alternative. If you do speak with your physician it is a good idea to ask your physician to complete this affidavit and keep a copy for his file.)

I, Dr. ____________________ have reviewed this guidance document and have discussed with ____________________ any questions regarding the probable medical consequences of the treatment choices provided above. This discussion with the principal occurred on (Date) ____________________.

I have agreed to comply with the provisions of this directive.

Signature of Physician ____________________

Verification

I affirm that: (1) I was present when this health care power of attorney was dated and signed or marked or (2) the person making this power of attorney directly indicated to me that the power of attorney expressed that person's wishes and that the person intended to adopt this power of attorney at that time.

I certify that: I have not been designated to make medical decisions for the person who signs this health care power of attorney. I am not directly involved with providing health care to that person, I am not related to that person by blood, marriage, or adoption and I am not entitled to any part of that person's estate.

Signature or Mark of Principal ____________________

Date: ____________________ Time: ____________________

Address of Agent ____________________ Telephone of Agent ____________________

Witness: ____________________ Address: ____________________

Witness: ____________________ Address: ____________________

(NOTE: This document may be notarized instead of being witnessed.)