Ohio's
Health Care
Power of Attorney

What you should know about a Health Care Power of Attorney:

A **Health Care Power of Attorney** is a document that allows you to name a person to act on your behalf to make health care decisions for you if you become unable to make them for yourself. **This person becomes an attorney-in-fact for you.**

- A **Health Care Power of Attorney** is different from a Financial Power of Attorney that you use to give someone authority over your financial matters.

- The person you appoint as your **attorney-in-fact**, by completing the **Health Care Power of Attorney** form, has the power to authorize and refuse medical treatment for you. **This authority is recognized in all medical situations when you are unable to express your own wishes**. Unlike a **Living Will**, it is not limited to situations in which you are terminally ill or permanently unconscious. For example, your physician or the hospital may consult with your attorney-in-fact should you be injured in a car accident and become temporarily unconscious.

- There are **five limitations** on the authority of your attorney-in-fact:

  1. **An attorney-in-fact has limited authority to order that life-sustaining treatment be withdrawn from you.** Your attorney-in-fact may order that life-sustaining treatment be refused or withdrawn only if you have a terminal condition or if you are in a permanently unconscious state. And even then, the attending physician and, if applicable, the consulting physician, must confirm that diagnosis, and your attending physician(s) must determine that you have no reasonable possibility of regaining decision-making ability.

  2. **Your attorney-in-fact does not have the authority to order the withdrawal of "comfort care."** Comfort care is any type of medical or nursing care that would provide you with comfort or relief from pain.

  3. **If you are pregnant, your attorney-in-fact cannot order the withdrawal of life-sustaining treatment unless certain conditions are met.** Life-sustaining treatment cannot be withdrawn if doing so would terminate the pregnancy unless there is substantial risk to your life or two physicians determine that the fetus would not be born alive.

  4. **Your attorney-in-fact may order that nutrition and hydration be withdrawn only if you are in a terminal condition or permanently unconscious state and two physicians agree that nutrition and hydration will no longer provide comfort or alleviate pain.** If you want to give your attorney-in-fact the authority to withhold nutrition and hydration if you were to become permanently unconscious, you must indicate this in the appropriate section of the **Health Care Power of Attorney** form. If you also have a **Living Will**, it should be consistent with your **Health Care Power of Attorney** regarding the withholding of nutrition and hydration. In other words, if you indicate in your **Health Care Power of Attorney** that it is permissible for your attorney-in-fact to order that nutrition and hydration be withheld, then you also should indicate in your **Living Will** that it is permissible for your physician to withhold nutrition and hydration.

  5. **If you previously have given consent for treatment (before becoming unable to communicate), your attorney-in-fact cannot withdraw your consent unless certain conditions are met.** Either your physical condition must have changed and/or the treatment you approved is no longer of benefit or the treatment has not been proven effective.

If you have a **Health Care Power of Attorney** and a **Living Will**, health care workers must follow the wishes you state in your **Living Will**, once the **Living Will** becomes effective. In other words, your **Living Will** takes precedence over your **Health Care Power of Attorney**.

You can change your mind and revoke your **Health Care Power of Attorney** at any time. You can do this simply by telling your attorney-in-fact, your physician and your family that you have changed your mind and wish to revoke your **Health Care Power of Attorney**. In this case, it is probably a good idea to ask for a copy of the document back from anyone to whom you may have given it.

How to fill out the Health Care Power of Attorney form:

You should use this form to appoint someone to make health care decisions for you if you should become unable to make them for yourself.

NOTE:

1. Read over all information carefully. Definitions are included as part of the form.

2. On the first two lines of the form, print your full name and birth date.

3. Under, "Naming of My Agent," fill in the name of the person you are appointing as your attorney-in-fact, the agent's current address and telephone number. You may name alternate agents on the indicated spaces; if you choose not to name alternate agents, you may wish to cross out the unused lines. You may not name your attending physician or the administrator of any nursing home where you are receiving care as your attorney-in-fact.

4. On the fifth page of the form, written in bold face type under ***Special Instructions***, is the statement that will give your physician permission to withhold food and water in the event you are permanently unconscious. If you want to give your physician permission to withhold food and water in this situation, then you must place your initials on the line indicated in number three.

5. The form provides a section where you may write additional instructions and impose additional limitations that you may consider appropriate to document. You may attach additional pages if needed. You should include all attached pages with any copy(ies) you make and you should note the attached pages on the form itself in the related area.

6. Following "Additional Instructions or Limitations" is a section where you indicate whether or not you have a **Living Will**. Immediately below this area are spaces to date and sign the form. Remember, the **Health Care Power of Attorney** is not considered valid or effective unless you do one of the following:

> **First Option** – Date and sign the **Health Care Power of Attorney** in the presence of two witnesses, who also must sign and include their addresses and indicate the date of their signatures.
>
> OR
>
> **Second Option** – Date and sign the **Health Care Power of Attorney** in the presence of a notary public and have the **Health Care Power of Attorney** notarized on the appropriate space provided on the form.

The following people may **not** serve as a witness to your **Health Care Power of Attorney**:

- The Agent and any successor agent named in this document;
- Anyone related to you by blood, marriage, or adoption, including your spouse and your children;
- Your attending physician or, if you are in a nursing home, the administrator of the nursing home.

7. NOTE: The section titled NOTICE TO ADULT EXECUTING THIS DOCUMENT is required by law to be part of the document and must accompany it and any copies distributed.

State of Ohio
Health Care Power of Attorney
of

_____

(Print Full Name)

_____

(Birth Date)

I state that this is my Health Care Power of Attorney and I revoke any prior Health Care Power of Attorney signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

This Health Care Power of Attorney is in effect only when I cannot make health care decisions for myself. However, this does not require or imply that a court must declare me incompetent.

Definitions. Several legal and medical terms are used in this document. For convenience they are explained below.

Agent or **attorney-in-fact** means the adult I name in this Health Care Power of Attorney to make health care decisions for me.

Anatomical gift means a donation of all or part of a human body to take effect upon or after death.

Artificially or technologically supplied nutrition or hydration means the providing of food and fluids through intravenous or tube "feedings".

Cardiopulmonary resuscitation or CPR means treatment to try to restart breathing or heartbeat. CPR may be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving electric shock to the chest, or by other means.

Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

Donor Registry Enrollment Form means a form that has been designed to allow individuals to specifically register their wishes regarding organ, tissue and eye donation with the Ohio Bureau of Motor Vehicles Donor Registry.

Do Not Resuscitate or **DNR Order** means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

Health care means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

Health Care Power of Attorney means this document that allows me to name an adult person to act as my agent to make health care decisions for me if I become unable to do so.

Life-sustaining treatment means any health care, including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

Living Will Declaration or **Living Will** means another document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

Permanently unconscious state means an irreversible condition in which I am permanently unaware of myself and surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

Principal means the person signing this document.

Terminal condition or **terminal illness** means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not receive life-sustaining treatment.

[Instructions and other information to assist in completing this document are set forth within brackets and in italic type.]

Naming of My Agent. The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's Name: _____

Agent's Current Address: _____

Agent's Current Telephone Number: _____

Naming of Alternate Agents. *[Note: You do not need to name alternate agents. You also may name just one alternate agent. If you do not name alternate agents or name just one alternate agent, you may wish to cross out the unused lines.]*

Should my agent named above not be immediately available or be unwilling or unable to make decisions for me, then I name, in the following order of priority, the following persons as my alternate agents:

First Alternate Agent:

Name: _____

Address: _____

_____

Telephone: _____

Second Alternate Agent:

Name: _____

Address: _____

_____

Telephone: _____

Any person can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

Guidance to Agent. My agent will make health care decisions for me based on the instructions that I give in this document and on my wishes otherwise known to my agent. If my agent believes that my wishes as made known to my agent conflict with what is in this document, this document will control. If my wishes are unclear or unknown, my agent will make health care decisions in my best interests. My agent will determine my best interests after considering the benefits, the burdens, and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

Authority of Agent. My agent has full and complete authority to make all health care decisions for me whenever I cannot make such decisions, unless I have otherwise indicated below. This authority includes, but is not limited to, the following: *[Note: Cross out any authority that you do **not** want your agent to have.]*

1. To consent to the administration of pain-relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death. My comfort and freedom from pain are important to me and should be protected by my agent and physician.

2. If I am in a terminal condition, to give, to withdraw or to refuse to give informed consent to life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.

3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, intervention or other measure.

4. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all my medical and health care records.

5. To consent to further disclosure of information, and to disclose medical and related information concerning my condition and treatment to other persons.

6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.

7. To execute consents, waivers, and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any third party who acts under this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.

8. To select, employ, and discharge health care personnel and services providing home health care and the like.

9. To select, contract for my admission to, transfer me to, or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.

10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, should I become unable to make health care decisions for myself in a place where this document is not enforced.

11. To complete and sign for me the following:

    (a) Consents to health care treatment, or the issuance of Do Not Resuscitate (DNR) Orders or other similar orders; and

    (b) Requests for my transfer to another facility, to be discharged against health care advice, or other similar requests; and

    (c) Any other document desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

Special Instructions. **By placing my initials at number 3 below, I want to specifically authorize my agent to refuse, or if treatment has commenced, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration if:**

1. **I am in a permanently unconscious state; and**

2. **My physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain; and**

3. **I have placed my initials on this line: _____**

Limitations of Agent's Authority. I understand that under Ohio law, there are five limitations to the authority of my agent:

1. My agent cannot order the withdrawal of life-sustaining treatment unless I am in a terminal condition or a permanently unconscious state, and two physicians have confirmed the diagnosis and have determined that I have no reasonable possibility of regaining the ability to make decisions; and

2. My agent cannot order the withdrawal of any treatment given to provide comfort care or to relieve pain; and

3. If I am pregnant, my agent cannot refuse or withdraw informed consent to health care if the refusal or withdrawal would end my pregnancy, unless the pregnancy or health care would create a substantial risk to my life or two physicians determine that the fetus would not be born alive; and

4. My agent cannot order the withdrawal of artificially or technologically supplied nutrition or hydration unless I am terminally ill or permanently unconscious and two physicians agree that nutrition or hydration will no longer provide comfort or relieve pain and, in the event that I am permanently unconscious, I have given a specific direction to withdraw nutrition or hydration elsewhere in this document; and

5. If I previously consented to any health care, my agent cannot withdraw that treatment unless my condition has significantly changed so that the health care is significantly less beneficial to me, or unless the health care is not achieving the purpose for which I chose the health care.

Additional Instructions or Limitations. I may give additional instructions or impose additional limitations on the authority of my agent. *[Note: On the lines below you may write in additional instructions or limitations. Here you may include any specific instructions or limitations you consider appropriate, such as instructions to refuse specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. If the space below is not sufficient, you may attach additional pages. If you include additional instructions or limitations here and your wishes change, you should complete a new Health Care Power of Attorney and tell your agent about the changes. If you do not have any additional instructions or limitations, you may wish to write "None" below or cross out the unused lines.]*

No Expiration Date. This Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time.

Guardian. I intend that the authority given to my agent will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start, I nominate my agent to serve as the guardian of my person, without bond.

Enforcement by Agent. My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document.

Release of Agent's Personal Liability. My agent will not incur any personal liability to me or my estate for making reasonable choices in good faith concerning my health care.

Copies the Same as Original. Any person may rely on a copy of this document.

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law.

Living Will. I have completed a Living Will: _____ Yes _____ No

Anatomical Gift(s). I have made my wishes known regarding organ and tissue donation in my Living Will: _____ Yes _____ No

Donor Registry Enrollment Form. I have completed the Donor Registry Enrollment Form: _____ Yes _____ No

SIGNATURE

[See next page for witness or notary requirements.]

I understand the purpose and effect of this document and sign my name to this Health Care Power of Attorney on _____ , 20 _____ , at _____, Ohio.

_____

PRINCIPAL

[You are responsible for telling members of your family and your physician about this document and the name of your agent. You also may wish, but are not required to tell your religious advisor and your lawyer that you have signed a Health Care Power of Attorney. You may wish to give a copy to each person notified.]

[You may choose to file a copy of this Health Care Power of Attorney with your county recorder for safekeeping.]

WITNESSES OR NOTARY ACKNOWLEDGMENT

[Choose one]

[This Health Care Power of Attorney will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, **or** *it is acknowledged before a Notary Public.]*

[The following persons ***cannot*** *serve as a witness to this Health Care Power of Attorney: the agent; any successor agent named in this document; your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician; or, if you are in a nursing home, the administrator of the nursing home.]*

Witnesses. I attest that the Principal signed or acknowledged this Health Care Power of Attorney in my presence, that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence. I further attest that I am not an agent designated in this document, I am not the attending physician of the Principal, I am not the administrator of a nursing home in which the Principal is receiving care, and I am an adult not related to the Principal by blood, marriage or adoption.

_____ residing at _____

Signature

_____ _____ , _____

Print Name

Dated: _____ , 20_____

_____ residing at _____

Signature

_____ _____ , _____

Print Name

Dated: _____ , 20_____

OR

Notary Acknowledgment.

State of Ohio

County of _____ ss.

On _____, 20_____ , before me, the undersigned Notary Public, personally appeared _____ , known to me or satisfactorily proven to be the person whose name is subscribed to the above Health Care Power of Attorney as the Principal, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____

Notary Public

My Commission Expires: _____