NOTICE TO THE INDIVIDUAL SIGNING
THE POWER OF ATTORNEY FOR HEALTH CARE

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your "Health Care Agent." Your Agent is the person you Trust to make health care decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of Agent in writing. The written form is often called an "Advance Directive." You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and on-line resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

WHAT ARE THE THINGS I WANT MY HEALTH CARE AGENT TO KNOW?

The selection of your Agent should be considered carefully, as your Agent will have the ultimate decision making authority once this document goes into effect, in most instances after you are no longer able to make your own decisions. While the goal is for your Agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your Agent to make decisions to direct or refuse health care interventions or withdraw treatment. Your Agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is important to talk with your Agent and your family about such things as:

(i) What is most important to you in your life?

(ii) How important is it to you to avoid pain and suffering?

(iii) If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?

(iv) Would you rather be at home or in a hospital for the last days or weeks of your life?

(v) Do you have religious, spiritual, or cultural beliefs that you want your Agent and others to consider?

(vi) Do you wish to make a significant contribution to medical science after your death through organ or whole body donation?

(vii) Do you have an existing advanced directive, such as a Living Will, that contains your specific wishes about health care that is only delaying your death? If you have another advance directive, make sure to discuss with your Agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your Agent agrees to honor the wishes expressed in your advance directive.

ILLINOIS STATUTORY SHORT FORM
POWER OF ATTORNEY FOR HEALTH CARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTH CARE. (You must sign this form and a Witness must also sign it before it is valid)

of , (Address),

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT (an Agent is your personal representative under state and federal law): of ,

(Agent phone number)

SUCCESSOR HEALTH CARE AGENT(S)

If the Agent I selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my Successor Health Care Agent(s). If a Guardian of my person is to be appointed I nominate the Agent under this Power of Attorney as Guardian. Only one person at a time can serve as my Agent (add another page if you want to add more Successor Agent names):

, , , Phone:

(Successor Agent #1 name, address and phone number)

MY AGENT CAN MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING:

(i) Deciding to accept, withdraw or decline treatment for any physical or mental condition of mine, including life-and-death decisions.

(ii) Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.

(iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

(iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue or whole body donation, autopsy, cremation, and burial. You should let your Agent know whether you are registered as a donor in the First Person Consent Registry maintained by the Illinois Secretary of State or whether you have agreed to donate your whole body for medical research on education.

The above grant of power is intended to be as broad as possible so that my Agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

Such power includes, but it is not limited, to behavioral or mental health information/records (740 ILCS 110/1 et seq.); HIV/AIDS-related health information/records (410 ILCS 305/9); drug/alcohol diagnosis, treatment, referral information (20 ILCS 301/30.5); Genetic testing information/records (410 ILCS 513/30).

I AUTHORIZE MY AGENT TO

( ) Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

( ) Make decisions for me only when I cannot make them for myself. The physician(s) caring for me will determine when I lack this ability. Starting now, to assist me with my health care plans and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them with others as needed, and the complete ability to communicate with my personal physician(s) and other health care providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself.

( ) Make decisions for me starting now and continuing after I can no longer make them for myself. While I can still make my own decisions, I can still do so if I want to.

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your Agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your Agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your Agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements.

SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES (optional):

( ) The quality of my life is more important than the length of my life. Suppose I am unconscious and my attending physician believes, under reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings. In that case, I do not want treatments to prolong my life or delay my death, but I want treatment or care to make me comfortable and relieve me of pain.
( ) Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible under reasonable medical standards.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that my Agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures. Health care providers may take direction from my Agent by phone, FaceTime, Zoom, or other remote methods. If you wish to limit the scope of your Agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically in this form.

It is my intention that my Agent shall have the same access to my medical records (and shall be my "personal representative" for all purposes of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that I have._____

My signature: _____

Today's date: _____

Witness Statement

The undersigned witness certifies that , known to me to be the same person whose name is subscribed as Principal to the foregoing Health Care Power of Attorney, appeared before me and the Notary Public and acknowledged signing, while the Principal was physically present in the State of Illinois, and delivering the instrument as the free and voluntary act of the Principal, for the uses and purposes therein set forth. I believe the Principal to be of sound mind and memory. The undersigned witness also certifies that the witness is not: (a) the attending physician or mental health service provider or a relative of the physician or provider; (b) an owner, operator, or relative of an owner or operator of a health care facility in which the Principal is a patient or resident; (c) a parent, sibling, descendant, or any spouse of such parent, sibling, or descendant of either the Principal or any Agent or successor agent under the foregoing Power of Attorney, whether such relationship is by blood, marriage, or adoption; or (d) an Agent or Successor Agent under the foregoing Power of Attorney.

_____ _____

Signature Print Name (Name)

Date: _____,

Address:

(**NOTE:** Illinois requires only one Witness, but other jurisdictions may require more than one Witness. If you wish to have a second Witness, have him or her certify and sign here:)

Signature	Print Name
Date:	
Address:	

NOTE: You may, but are not required to, notarize your executed Power of Attorney, request your Agent and Successor Agents to provide specimen signatures, and identify the name, if any, of the preparer who assisted you in completing this form, as provided below. If you include specimen signatures in this Power of Attorney, you must complete the certification opposite the signatures of the Agents; you may also have the notary certify the correctness of Agent signatures.)

State of Illinois)
) SS.
County of)

The undersigned, a Notary Public in and for the above state and county, certifies that , known to me to be the same person whose name is stated as Principal to this Power of Attorney, appeared before me and the Witness named above and acknowledged signing and delivering the instrument as the free and voluntary act of the Principal, for the uses and purposes therein set forth herein, (and certified to the correctness of the signature(s) of the Agent(s).

Dated: _____.

Signature

_____

Specimen signatures of Agent (and Successors)

_____

Notary Public

I certify that the signatures of my Agent (and Successors) are correct.

(Agent)	(Principal)
(Successor Agent)	(Principal)
(Successor Agent)	(Principal)

Agent Authorization

The Statutory short form Power of Attorney for Health Care (the "Statutory Health Care Power") authorizes the Agent to make any and all health care decisions on behalf of the Principal which the Principal could make if present and under no disability, subject to any limitations on the granted powers that appear on the face of the form, to be exercised in such manner as the Agent deems consistent with the intent and desires of the Principal. The Agent will be under no duty to exercise granted powers or to assume control of or responsibility for the Principal's health care; but when granted powers are exercised, the Agent will be required to use due care to act for the benefit of the Principal in accordance with the terms of the Statutory Health Care Power and will be liable for negligent exercise. The Agent may act in person or through others reasonably employed by the Agent for that purpose but may not delegate authority to make health care decisions. The Agent may sign and deliver all instruments, negotiate and enter into all agreements and do all other acts reasonably necessary to implement the exercise of the powers granted to the Agent. Without limiting the generality of the foregoing, the Statutory Health Care Power shall include the following powers, subject to any limitations appearing on the face of the form:

(1) The Agent is authorized to give consent to and authorize or refuse, or to withhold or withdraw consent to, any and all types of medical care, treatment or procedures relating to the physical or mental health of the Principal, including any medication program, surgical procedures, life-sustaining treatment or provision of food and fluids for the Principal.

(2) The Agent is authorized to admit the Principal to or discharge the Principal from any and all types of hospitals, institutions, homes, residential or nursing facilities, treatment centers and other health care institutions providing personal care or treatment for any type of physical or mental condition. The Agent shall have the same right to visit the Principal in the hospital or other institution as is granted to a spouse or adult child of the Principal, any rule of the institution to the contrary notwithstanding.

(3) The Agent is authorized to contract for any and all types of health care services and facilities in the name of and on behalf of the Principal and to bind the Principal to pay for all such services and facilities, and to have and exercise those powers over the Principal's property as are authorized under the Statutory Property Power, to the extent the Agent deems necessary to pay health care costs; and the Agent shall not be personally liable for any services or care contracted for on behalf of the Principal.

(4) At the Principal's expense and subject to reasonable rules of the health care provider to prevent disruption of the Principal's health care, the Agent shall have the same right the Principal has to examine and copy and consent to disclosure of all the Principal's medical records that the Agent deems relevant to the exercise of the Agent's powers, whether the records relate to mental health or any other medical condition and whether they are in the possession of or maintained by any physician, psychiatrist, psychologist, therapist, hospital, nursing home or other health care provider. The authority under this paragraph (4) applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder. The Agent serves as the Principal's personal representative, as that term is defined under HIPAA and regulations thereunder.

(5) The Agent is authorized: to direct that an autopsy be made pursuant to Section 2 of "An Act in relation to autopsy of dead bodies", approved August 13, 1965, including all amendments; to make a disposition of any part or all of the Principal's body pursuant to the Illinois Anatomical Gift Act, as now or hereafter amended; and to direct the disposition of the Principal's remains.