MISSOURI
HEALTH CARE DIRECTIVE
AND
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

OF

Jane Doe

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SAMPLE

I. HEALTH CARE DIRECTIVE

1. I, Jane Doe, make this HEALTH CARE DIRECTIVE ("Directive") to exercise my right to determine the course of my health care and to provide clear and convincing proof of my choices and instructions about my treatment.

[This section will appear if you elect to be kept on life support.]

2. I willfully and voluntarily make known my desire to prolong my life as long as reasonably possible within the limits of generally accepted health-care standards.

[This section will appear if you elect to not be kept on life support and will vary depending on your choices.]

2. If I am persistently unconscious or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, I direct that all of the life-prolonging procedures that I have initialed below be withheld or withdrawn:

(initial) _____ artificially supplied nutrition and hydration (including tube feeding of food and water)

(initial) _____ surgery or other invasive procedures

(initial) _____ heart-lung resuscitation (CPR)

(initial) _____ antibiotics

_____
(Initial)

(initial) _____ dialysis

(initial) _____ mechanical ventilator (respirator)

(initial) _____ chemotherapy

(initial) _____ radiation therapy

(initial) _____ all other "life-prolonging" medical or surgical procedures that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury

If I am pregnant, and that fact is known to my physician, this section will have no force or effect during my pregnancy.

3. If, however, my physician believes that any life-prolonging procedure may lead to a recovery significant to me as communicated by me, or any health care attorney-in-fact named by me, to my physician, then I direct my physician to try the treatment for a reasonable period of time. If it does not cause my condition to improve, I direct the treatment to be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, except as stated below: If they are addictive.

[This section will appear if you write additional health care instructions.]

4. I further direct that: Sample.

[This section appears if you choose to appoint someone to make health care decisions for you. You can appoint an alternate agent if your first choice is unavailable.]

II. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. **Selection of Agent**. I, Jane Doe, currently a resident of [COUNTY] County, Missouri, appoint the following person as my true and lawful attorney-in-fact ("Agent"):

Name: John Doe
Relation: Spouse
Address: 100 Main Street

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[CITY], Missouri [ZIP]
Phone: (555) 555-5555
Alt. Phone: (444) 444-4444
Email: jdoe@legalzoomsample.com

2. **Alternate Agent.** If my Agent resigns or is not able or available to make health care decisions for me, or if an Agent named by me is divorced from me or is my spouse and legally separated from me, I appoint the following person to serve as my alternate Agent and to have the same powers as my Agent:

Name: Ann Doe
Relation: Daughter
Address: 100 Main Street
[CITY], Missouri [ZIP]
Phone: (333) 333-3333
Alt. Phone: (222) 222-2222
Email: adoe@legalzoomsample.com

3. **Durability**. This is a Durable Power of Attorney, and the authority of my Agent, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

4. **Effective Date**. This Durable Power of Attorney is effective when I am incapacitated and unable to make and communicate a health-care decision as certified by two physicians.

5. **Agent's Powers**. I grant to my Agent full authority to:

A. Give consent to, prohibit, or withdraw any type of health care, long-term care, hospice or palliative care, medical care, treatment, or procedure, whether in my residence or a facility outside of my residence, even if my death may result, including, but not limited to, an out-of-hospital do-not-resuscitate order form, with the following specific authorization:

(initial) _____ I wish to AUTHORIZE my Agent to direct a health care provider to withhold artificially supplied nutrition and hydration (including tube feeding of food and water).

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(initial) _____ I DO NOT AUTHORIZE my Agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water).

B. Make all necessary arrangements for health care services on my behalf and hire and fire medical personnel responsible for my care;

C. Move me into or out of any health care or assisted living/residential care facility or my home (even if against medical advice) to obtain compliance with the decisions of my Agent;

D. Take any other action necessary to do what I authorize here, including, but not limited to, granting any waiver or release from liability required by any health care provider and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney for Health Care;

E. Receive information regarding my health care, obtain copies of and review my medical records, consent to the disclosure of my medical records, and act a my "personal representative" as defined in the regulations [45 C..R. 164.502 (g)] enacted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

F. Execute an outside-the-hospital do-not-resuscitate order form as my patient's representative;

G. Do one or more of the following:

(initial) _____ Determine what happens to my body after my death;

(initial) _____After my death, consent or withhold consent to an autopsy or postmortem examination of my remains;

(initial) _____ Delegate health care decision-making power to another person ("Delegee") as elected by my Agent; provided that my Agent shall identify any Delegee in writing.

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(Initial)

[This section varies depending upon your choices regarding organ donation.]

H. Make an anatomical gift of my body or part (organ or tissue). I hereby authorize the making of anatomical gifts of the following parts of my body for the following purposes:

Gift:	All organs and parts.
Purpose:	Medical purposes, education, and research.

If I have already consented to be on the Missouri organ and tissue donor registry, or any health care attorney-in-fact named by me has authorized the donation of my organs or tissues, I realize it may be necessary to maintain my body artificially after my death until my organs or tissues can be removed.

[The following section appears if you place limitations on your agent's authority.]

I. Notwithstanding the foregoing, the authority of my Agent is limited as follows: Sample.

6. **Agent's Financial Liability and Compensation**. My Agent, acting under this Durable Power of Attorney for Health Care, will incur no personal financial liability. My Agent is not entitled to compensation for services performed under this Durable Power of Attorney for Health Care, but my Agent is entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions hereof.

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III. GENERAL PROVISIONS

1. **Relationship Between Health Care Directive and Durable Power for Attorney for Health Care**. I have executed both the Directive and Durable Power of Attorney for Health Care, I encourage my Agent to:

A. First, follow my choices as expressed in the above Directive or otherwise from knowing me or having had various discussions with me about making decisions regarding life-prolonging procedures.

B. Second, if my Agent does not know my choices for the specific decision at hand, but my Agent has evidence of my preferences, my Agent can determine how I would decide. My Agent should consider my values, religious beliefs, past decisions, and past statements. The aim is to choose as I would choose, *even if it is not what my Agent would choose for himself or herself*.

C. Third, if my Agent has little or no knowledge or choices I would make, then my Agent and the physicians will have to make a decision based on what a reasonable person in the same situation would decide. I have confidence in my Agent's ability to make decisions in my best interest if my Agent does not have enough information to follow my preferences.

D. Finally, if the Durable Power of Attorney for Health Care is determined to be ineffective, or if my Agent is not able to serve, the Directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

2. **Protection of Third Parties Who Rely on My Agent**. No person who relies in good faith on any representations made by my Agent or alternate Agent will be liable to me, my estate, heirs, or assigns, for recognizing the Agent's authority.

3. **Revocation of Health Care Directive or Prior Durable Power for Attorney for Health Care**. I revoke any prior living will, declaration, or health care directive executed by me. If I have appointed an Agent in a prior durable power of attorney, I revoke any prior health care durable powers of attorney or any health care terms contained in such other durable powers of attorney and intend that this Durable Power for

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Attorney for Health Care and this Directive replace or supplant earlier documents or provisions or earlier documents.

4. **Validity**. This document is intended to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document is as valid as the original.

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IN WITNESS WHEREOF, I sign this document on the date below:

_____
Signature of Jane Doe

Dated: _____, 20___

100 Main Street
[CITY], Missouri [ZIP]

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(Initial)

WITNESS DECLARATIONS

Under penalty of perjury, each of the undersigned declares that: (1) Jane Doe has been personally known to me (or that the individual's identity was proven to me by convincing evidence), and I believe him or her to be of sound mind and not under duress, fraud, or undue influence; (2) Jane Doe signed or acknowledged this document in my presence, and I did not sign Jane Doe's signature; (3) I am not related to Jane Doe by blood, adoption, or marriage; (4) I am not entitled to any part of Jane Does estate or directly financially responsible for his or her medical care; (5) I am competent and at least eighteen years of age; (6) I am not Jane Doe's doctor or physician, or an employee of Jane Doe's doctor or physician; and (7) I am not the operator or an employee of a community care facility or a residential care facility for the elderly.

Signature:_____

Print Name:_____

Address:_____

_____

Signature:_____

Print Name:_____

Address:_____

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ACKNOWLEDGMENT
OF NOTARY PUBLIC

State of Missouri

County of [COUNTY]

On this _____ day of _____, 20___, before me, personally appeared Jane Doe, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the county or city and state aforementioned, on the day and year first above written.

_____
Signature of Notary Public

_____, Notary Public
Print Name

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