HEALTHCARE POWER OF ATTORNEY FORM

Using this Healthcare Power of Attorney form, created as a courtesy by Penn Medicine Lancaster General Health, I, ______________________________ , appoint the person named below as my healthcare agent to make healthcare decisions on my behalf when I am unable to make healthcare decisions myself. I acknowledge that if I do not appoint a person, the person(s) identified in 20 Pa.C.S.A. §5461(d) are authorized to make healthcare decisions for me.

MY HEALTHCARE AGENT

Name: ______________________________

Street Address: ______________________________

City, State, Zip Code: ______________________________

Telephone: (   ) ____________________ Cell Phone: (   ) ____________________

MY FIRST ALTERNATE HEALTHCARE AGENT

If the person named above is unable or unwilling to serve as my healthcare agent, I appoint the following individual as my alternate healthcare agent:

Name: ______________________________

Street Address: ______________________________

City, State, Zip Code: ______________________________

Telephone: (   ) ____________________ Cell Phone: (   ) ____________________

AUTHORITY OF MY HEALTHCARE AGENT

My healthcare agent has the authority to make the following healthcare decisions on my behalf subject to my living will. *(Cross out any powers you do not want to give your healthcare agent)*:

1. To authorize, withhold, or withdraw medical care and surgical procedures.
2. To authorize, withhold, or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries, or veins.
3. To authorize my admission to, or discharge from, a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.
4. To hire and fire medical, social service, and other support personnel responsible for my care.
5. To take any legal action necessary to do what I have directed.
6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

SIGNATURES

Pennsylvania law protects my healthcare agent and healthcare providers from any legal liability for their good faith actions in following my wishes as expressed in this document or in complying with my healthcare agent's direction. On behalf of myself, my executors, and heirs, I further hold my healthcare agent and my healthcare providers harmless and indemnify them against any claim for their good faith actions in recognizing my healthcare agent's authority or in following my treatment instructions.

Having carefully read this document, I have signed it this ______________ day of ______________, 20______, revoking all previous healthcare powers of attorney.

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(Signature)

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of the principal may not be a witness.

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(Witness Signature) (Witness Printed Name)

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(Witness Signature) (Witness Printed Name)

Provided by Penn Medicine Lancaster General Health 7/29/2022

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