Name, MR#, Pat#, DOB

DENVER HEALTH MEDICAL CENTER

MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

Primary Language: ☐ English ☐ Spanish ☐ Other_____ ID X 2 _____ (Staff Initials)

Do you wish to have an interpreter? ☐ Yes ☐ No ☐ N/A Interpreter: _____ (Name)

☐ Language Line Used ☐ Patient requests to have significant other/family member interpret. _____ (Name)

Communication Aids Requested? ☐ Yes ☐ No ☐ N/A If yes: _____

IMPORTANT INFORMATION ABOUT THE FOLLOWING LEGAL DOCUMENT

Before signing this document, it is very important for you to know and understand these facts:

- This document gives the person you name as your agent the power to make health care decisions if you are unable to do so. These decisions and powers are not limited to terminal conditions and life support decisions.
- After you have signed this document, you still have the right to make health care decisions for yourself if you are able to do so.
- You may state in this document any type of treatment that you want to receive or want to avoid. If you want your agent to make decisions about life sustaining treatment, it is best to so state in your medical durable power of attorney.
- You have the right to take away the authority of your agent to make decisions for you at any time unless you have been determined to be incompetent by a court. If you withdraw (revoke) the authority of your agent, you should do so in writing and give copies to all those who received the original document.
- You should not sign this document unless you understand it. You may wish to talk to others or a lawyer before you sign this document.
- You may use this sample Medical Durable Power of Attorney form; however, it may not meet your individual needs. Other medical durable power of attorney forms are acceptable to use in Colorado also. Be sure the form you sign meets your needs.
- The enclosed Medical Durable Power of Attorney form complies with Colorado law. Witness, notary, and other requirements vary from state to state. If you move to another state or travel often, be sure to check that state's requirements.

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Your medical durable power of attorney should contain the following information:

- The name, address and telephone number of the person you choose as your agent, and your second choice of agent to act if your first agent is unable to act for you.
- Any instructions about treatment you do or do not wish to receive such as surgery, chemotherapy, or life sustaining treatment such as artificial feeding, kidney dialysis, or breathing support, etc.

Name, MR#, Pat#, DOB

DENVER HEALTH MEDICAL CENTER

MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

1. I, _____, Declarant, hereby appoint:
(Print Your Name)

_____
Name of Agent

_____
Agent's Home Telephone Number

_____
Agent's Work Telephone Number

_____
Agent's Home Address

as my agent to make health care decisions for me if and when I am unable to make my own health care decisions. This gives my agent the power to consent, to refuse, or to stop any health care, treatment, service or diagnostic procedure. My agent also has the authority to talk with health care personnel, get information, and sign forms necessary to carry out those decisions.

If the person named as my agent is not available or is unable to act as my agent, then I appoint the following person(s) to serve in the order listed below:

2. _____
Agent Name

_____
Home Telephone # Work Telephone #

3. _____
Agent Name

_____
Home Telephone # Work Telephone #

By this document I intend to create a **Medical Durable Power of Attorney** which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity.

My agent shall make health care decisions as I may direct below or as I make known to him or her in some other way. If I have not expressed a choice about the health care in question, my agent shall base his/her decision on what he/she believes to be in my best interest.

(A) Statement of desires concerning life-prolonging care, treatment, services and procedures:

_____

_____

_____

(B) Special provisions and limitations:

_____

_____

_____

BY SIGNING HERE, I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

_____ _____
SIGNATURE OF PERSON CREATING MEDICAL DURABLE POWER OF ATTORNEY **DATE**

(Optional But Recommended)
Colorado law does not require this document to be witnessed; however, it is recommended to obtain the signature of 2 witnesses or a notary. This is not required by Colorado law but may make this document more acceptable in other states.

WITNESS:
Signature: _____
Home Address: _____

_____
Date: _____

WITNESS:
Signature: _____
Home Address: _____

_____
Date: _____