

# Healthcare Power of Attorney of Carol Sample

I, Carol Sample the principal, an adult of sound mind, execute this Healthcare Power of Attorney freely and voluntarily, with an understanding of its purposes and consequences. I intend to create a medical durable power of attorney under the laws of the State of Delaware. I further intend to demonstrate my wishes concerning medical treatment with clear and convincing evidence.

## STATEMENT OF INTENT

**I am making this statement of intent as a guide to my Healthcare Representative and as an expression of the extent of my Representative's authority. Notwithstanding this statement, it is my intent that the ultimate decision of my care rests with my Representative and not with a medical provider interpreting this Statement of Intent or any other provision of this Healthcare Power of Attorney.**

One of my primary purposes in executing this Durable Power of Attorney for Health Care is to provide for the possibility that, through illness or incapacity, I may lose the ability to care for myself and to interact with others. If I have a terminal condition or an end-stage condition, or if I am in a persistent vegetative state or am otherwise incapable of relating to others, it is my wish that no extraordinary measures, including life-sustaining procedures, be taken to prolong my life, or if such measures have been instituted, that they be discontinued. In addition, under such circumstances, I do not wish to have artificially administered food or hydration. If I am unable to communicate my wishes, I request my Agent's decision with respect to my care and to the elimination of extraordinary measures be guided by my preference, as herein expressed, in conjunction with the advice and information provided by the physicians treating me. In keeping with my preferences, my Agent may specifically request and concur with the writing of a "no-code" (do not resuscitate) if ordered by the attending or treating physician.

Recitals.

### **Section 1.1 Designation of Healthcare Agent**

I designate Donald Sample to serve as my Healthcare Representative. I give my Healthcare Representative the power to make decisions with regard to my health care if I am unwilling or unable to make my own health care decisions.

If Donald Sample is unwilling or unable to serve, I designate the individuals named below as alternate Healthcare Representatives, each of whom is individually referred to in this instrument as my Healthcare Representative, to exercise alone or jointly the powers and discretions set forth in this instrument: Sally Sample and Susan Sample.

## **Section 1.2 Duration**

This Healthcare Power of Attorney expires at the earliest of:

- my death (except for post-death matters allowed under Delaware law); or
- my revocation of this Healthcare Power of Attorney.

However, the medical information and medical records provisions described in [Section 2.04](#) continue in effect for an additional 24 months from the date of my death unless revoked. My Healthcare Agent's authority does not terminate if I become disabled or incapacitated.

## **Section 1.3 General Grant**

My Healthcare Agent may determine and implement all actions necessary for my personal care, residential placement, and medical treatment, including the items specifically mentioned in this instrument. If my Healthcare Agent is not available, I intend to guide decisions about my care and treatment with the following statements.

## **Section 1.4 Effect on Legal Capacity**

A formal adjudication of my incapacity is not required for my Healthcare Agent to exercise the authority granted by me under this instrument. In fact, I emphasize that my Healthcare Representative has the power to exercise the authority granted under this instrument even if I have mental capacity.

When my life is on a decidedly downward trajectory, I will probably suffer with the physical and emotional distress that accompany many mortal illnesses and will probably compound the pained uncertainty of treatment with the further agony of indecision. In that situation, my Healthcare Representative is charged with the responsibility of making medical decisions for me not only when I cannot make them for myself but also when I don't want to make them for myself.

## **Article 2**

### **Health and Personal Powers**

#### **Section 2.1      Instructions Concerning Medical Evaluations and Treatment**

In exercising the authority granted to my Healthcare Agent, I instruct my Healthcare Agent to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner however rudimentary, even by blinking my eyes. I further instruct my Healthcare Agent that if I am unable to give an informed consent to medical treatment, my Healthcare Agent shall give or withhold consent based upon any treatment choices I have expressed while competent, whether under this instrument or otherwise. If my Healthcare Agent cannot determine the treatment choice I would want made under the circumstances, then I request that my Healthcare Agent make the choice for me based upon what my Healthcare Agent believes to be in my best interests. I request that my Healthcare Agent's decision be guided by taking into account:

the provisions of this instrument;

any preferences that I may have expressed on the subject;

what my Healthcare Agent believes I would want done in the circumstances if I were able to express myself; and

any information given to my Healthcare Agent by the physicians treating me as to my medical diagnosis and prognosis and the intrusiveness, pain, risks, and side effects of the treatment.

I want to leave my family, friends, and persons who care about me with assurances of my love, and without the burdens of guilt or conflict. My purposes in leaving these instructions are to alleviate uncertainty that otherwise may arise in connection with decisions about my medical care, to promote family harmony, and to clarify instructions to my health care providers. My Healthcare Agent's authority to act on my behalf concerning my medical care includes decisions concerning artificial life support, medical treatment, surgery and other medical procedures; artificial nourishment and hydration; resuscitation decisions (including Do Not Resuscitate [DNR] orders and Cardiopulmonary Resuscitation [CPR] directives); amputation of my limbs; blood transfusions; experimental drugs and medical procedures; the administration of pharmaceutical agents; arrangements for my longterm care.

I affirm my belief in the importance and value of my personal dignity, both in living and in dying.

## **Section 2.2 Dementia Care**

Under the conditions that may be imposed upon me by advanced dementia, including my inability to communicate comprehensively with loved ones or care givers, and my physical dependence on others for all aspects of bodily care, continuing life would have no value for me. In those conditions, I would want to die peacefully and as quickly as legally possible to avoid a drawn-out, prolonged dying that would involve unnecessary suffering for me and for those I love.

If my appointed health care agent concludes, after consultation with my primary health care provider, that I am suffering from advanced dementia and I am unable to feed myself, I want all medications and treatments that might prolong my life to be withheld or, if already begun, to be withdrawn, including cardio-pulmonary resuscitation and the provision of nutrition and hydration whether provided artificially or medically or by hand or by assisted oral feeding.

### **(a) Assisted Hand Feeding**

If I am suffering from advanced dementia and appear willing to accept food or fluid offered by assisted or hand feeding, my Healthcare Agent may discontinue feeding me by hand even if I appear to cooperate in being fed by opening my mouth.

## **Section 2.3 Longterm or Hospice Care**

My Healthcare Agent may select a facility for my nursing, convalescent, or hospice care and establish my residence and placement in a secure unit therein if the facility provides the quality of care appropriate for my medical needs and mental condition. For the purposes of arranging or providing longterm care, my Healthcare Agent has authority to facilitate my transportation and establish my legal residence within or beyond the state of Delaware.

## **Section 2.4 Medical Information and Medical Records**

Acting on my behalf, my Healthcare Agent may have access to all of my medical information and photocopies of my medical records from my health care providers including physicians, dentists, podiatrists, physical therapists, chiropractic physicians and chiropractors, pharmacists, optometrists, psychologists, social workers, hospitals, hospices, and other treatment facilities; may disclose medical and related information concerning my treatment to appropriate health care providers; and may admit or transfer me to such hospitals, hospices, or treatment facilities as my Healthcare Agent determines to be in my best interests.

In order for my Healthcare Agent to fulfill his or her duties, my treating physician or hospital is to discuss my medical condition with and disclose all medical records to my Healthcare Agent.

## **Section 2.5      Employ and Discharge Health Care Personnel**

My Healthcare Agent may employ and discharge medical personnel including physicians, psychiatrists, dentists, nurses, and therapists as my Healthcare Agent determines necessary for my physical, mental, and emotional well-being, and pay them reasonable compensation.

## **Section 2.6      Pain Relief**

I want to ensure that my Healthcare Agent and physician protect my comfort and freedom from pain insofar as possible. I authorize my Healthcare Agent to consent on my behalf to the administration of whatever pain-relieving drugs and pain-relieving surgical procedures my Healthcare Agent, upon medical advice, believes may provide comfort to me, even though such drugs or procedures may lead to pharmaceutical addictions, lower blood pressure, lower levels of breathing, or hasten my death. Even if artificial life support or aggressive medical treatment has been withdrawn or refused, I want to be kept as comfortable as possible, and I do not want to be neglected by medical or nursing staff.

## **Section 2.7      Consent to Psychiatric Treatment**

Upon the execution of a certificate by two independent psychiatrists who have examined me and in whose opinions I am in immediate need of hospitalization because of mental disorders, alcoholism, or drug abuse, my Healthcare Agent may arrange for my voluntary admission to an appropriate hospital or institution for treatment of the diagnosed problem or disorder; to arrange for private psychiatric and psychological treatment for me; and to revoke, modify, withdraw, or change consent to the hospitalization, institutionalization, or private treatment that I or my Healthcare Agent may have previously given. The consent of my Healthcare Agent to my hospitalization for psychiatric help, alcoholism, or drug abuse has the same legal effect, subject to applicable local law, as a voluntary admission made by me.

## **Section 2.8      Grant Releases**

My Healthcare Agent may grant, in conjunction with any instructions given under this instrument, releases from all liability for damages suffered or to be suffered by me to hospital staff, physicians, nurses, and other medical and hospital administrative personnel who act in reliance on instructions given by my Healthcare Agent or who render written opinions to my Healthcare Agent in connection with any matter described in this instrument. My Healthcare Agent may sign documents titled or purporting to be a *Refusal to Permit Treatment* and *Leaving Hospital Against Medical Advice* as well as any necessary waivers of or releases from liability required by any hospital or physician to implement my wishes regarding medical treatment or nontreatment.

## **Section 2.9      Living Will**

I have not executed a Living Will and I do not want my Healthcare Agent's powers to be limited by the terms or conditions of a Living Will.

If I become unconscious or incompetent in a state where this Healthcare Power of Attorney is not enforceable, I authorize my Healthcare Agent to transport me or arrange for my transportation to a jurisdiction where my medical directives will be enforceable.

### **Section 2.10 Anatomical Gifts for Any Purposes**

I authorize my Healthcare Agent to make anatomical gifts on my behalf to the persons and organizations my Healthcare Agent chooses for any purpose, including transplantation and medical research. My Healthcare Agent may execute the papers and act as necessary, appropriate, incidental, or convenient in connection with these gifts.

## **Article 3**

### **Legal and Administrative Powers and Provisions**

#### **Section 3.1 Health Insurance Portability and Accountability Act**

I grant my Healthcare Agent (my original representative(s) as well as any named alternates) the power and authority to serve as my authorized recipient for all purposes of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its regulations immediately upon my signing this document.

Pursuant to HIPAA, I specifically authorize my Healthcare Agent as my HIPAA-authorized recipient to request, receive, and review any information regarding my physical health, including all HIPAA-protected health information, medical, and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required to obtain this information; and to consent to the disclosure of this information. I further authorize my Healthcare Agent to execute on my behalf valid authorizations for the release of HIPAA-protected health information.

By signing this Healthcare Power of Attorney, I specifically authorize my physician, hospital, or health care provider to release any medical records to my Healthcare Agent or any person designated in a valid authorization for the release of HIPAA-protected health information executed by my Healthcare Agent. Further, I waive any liability to any physician, hospital, or health care provider that releases any of my medical records to my Healthcare Agent and acknowledge that the health information that would otherwise be protected under HIPAA will no longer be protected.

#### **Section 3.2 Guardian**

My Healthcare Agent's authority precludes the need for appointment of a Guardian. But if any proceeding is commenced for the appointment of a Guardian, I nominate my Healthcare Agent to serve as Guardian.

### **Section 3.3 Third-Party Reliance**

My Healthcare Agent's instructions and decisions regarding my medical treatment are binding on third parties. No person, medical facility, or institution will incur any liability to me or to my estate by complying with my Healthcare Agent's instructions. My Healthcare Agent is authorized to execute consents, waivers, and releases of liability on my behalf and on behalf of my estate to all medical personnel who comply with my Healthcare Agent's instructions. Furthermore, I authorize my Healthcare Agent to indemnify and hold harmless, at my expense, any third party who accepts and acts under this Healthcare Power of Attorney, and I agree to be bound by any indemnity entered into by my Healthcare Agent.

### **Section 3.4 Enforcement by Healthcare Agent**

I authorize my Healthcare Agent to seek on my behalf and at my expense:

a declaratory judgment from any court of competent jurisdiction interpreting the validity of this instrument or any of the acts authorized by this instrument, but a declaratory judgment is not required for my Healthcare Agent to perform any act authorized by this instrument;

an injunction requiring compliance with my Healthcare Agent's instructions by any person providing medical or personal care to me; or

actual and punitive damages against any person responsible for providing medical or personal care to me who willfully fails or refuses to follow my Healthcare Agent's instructions.

### **Section 3.5 Release of Healthcare Agent's Personal Liability**

My Healthcare Agent will not incur any personal liability to me or my estate arising from the good faith exercise of discretion or performance of acts and duties relating to my medical treatment and personal care.

### **Section 3.6 Reimbursement of Healthcare Agent**

My Healthcare Agent is entitled to reimbursement for all reasonable expenses arising from the performance of acts and duties relating to my medical treatment and personal care under this instrument.

### **Section 3.7 Copies Effective as Originals**

Photocopies of this instrument are effective and enforceable as originals, and third parties are entitled to rely on photocopies of this instrument for the full force and effect of all stated terms. The word *photocopies* includes facsimiles, digital, or other reproductions.

### **Section 3.8 Interstate Enforceability**

My intention is that the terms of this instrument be honored in any jurisdiction, regardless of its conformity to that jurisdiction's technical requirements and legal formalities.

### **Section 3.9      Amendment and Revocation**

I reserve the right to revoke my Healthcare Agent's authority orally or in writing.

### **Section 3.10     Revocation of Prior Powers**

Unless specifically excepted in this instrument, this Healthcare Power of Attorney supersedes any prior medical durable power of attorney that I have executed. But this instrument does not affect any other unrelated powers previously conveyed by me through general or limited powers of attorney; these powers are to continue in full force until revoked by me or otherwise terminated.

## **Article 4 Definitions**

### **Section 4.1      Shall and May**

Unless otherwise specifically provided in this document or by the context in which used, I use the word *shall* in this document to impose a duty, command, direction, or requirement, and the word *may* to allow or permit, but not require. In the context of my Healthcare Agent, when I use the word *shall*, I intend to impose a fiduciary duty on my Healthcare Agent. When I use the word *may*, I intend that my Healthcare Agent is empowered to act with sole and absolute discretion unless otherwise stated in this document.

Dated: February 5, 2020

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Carol Sample, Principal

STATE OF DELAWARE  
COUNTY OF SUSSEX

This instrument was acknowledged before me on February 5, 2020, by Carol Sample as Principal.

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John F. Lawyer: Notary Public

**Witness Attestation**

SIGNED and DECLARED by the above-named declarant as and for her written declaration, in our presence, who in her presence and at her request, and in the presence of each other, have hereunto subscribed our names as witnesses and state:

- A. The Declarant is mentally competent.
- B. That neither of us:
  - 1. Is related to the declarant by blood, marriage or adoption;
  - 2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of this Healthcare Power of Attorney, is so entitled by operation of law then existing;
  - 3. Has, at the time of the execution of this Healthcare Power of Attorney, a present or inchoate claim against any portion of the estate of the declarant;
  - 4. Has a direct financial responsibility for the declarant’s medical care;
  - 5. Has a controlling interest in or is an operator or an employee of a health care institution in which the declarant is a patient or resident; or is under eighteen years of age.

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Jane Smith, Witness  
 29 H Atlantic Ave.  
 Ocean View, DE 19970

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Joe Smith: Witness  
 29 H Atlantic Ave  
 Ocean View, DE 19970

Witness my hand and official seal.

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John F. Lawyer: Notary Public