- Warning to person executing this document -

This is an important legal document. Before executing this document you should know these important facts:

This document gives the person you designate as your agent (your attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent: (1) authorizes anything that is illegal; or (2) acts contrary to your desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to: (1) authorize an autopsy; (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes; and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask an attorney to explain it to you.

[Tennessee Code Annotated, § 68-11-1701 et seq.; Tennessee Healthcare Decisions Act.]

APPOINTMENT OF HEALTH CARE AGENT

By signing this document, I appoint the person I name on page 2 to make health care decisions for me if I am ever unable to make them for myself. I intend for this person to ensure that my Advance Care Plan (Living Will) if I have one is honored and that decisions about my medical care respect my wishes as far as they are known. I intend for this person to have the broadest discretion and power allowed by law to approve, refuse or stop medical care for me.

If I should ever reach the point at which my doctor believes I am going to die no matter what is done, I direct this person to ensure that I am allowed to die naturally. That means not starting or continuing to use machines or treatments that would only prolong my dying.

At that point, this person should ensure that I have only the medicine or treatment that I need to keep me comfortable and relieve pain.

APPOINTMENT OF HEALTH CARE AGENT

(Tennessee)

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:	Alternate:
_____ Name	_____ Name
_____ Address	_____ Address
_____ City State Zip Code	_____ City State Zip Code
( ) _____ Area Code Home Phone Number	( ) _____ Area Code Home Phone Number
( ) _____ Area Code Work Phone Number	( ) _____ Area Code Work Phone Number
_____ Area Code Mobile Phone Number	_____ Area Code Mobile Phone Number
_____ Patient's name (please print or type) Date	_____ Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, **either** block A **or** block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named above. I witnessed the patient's signature on this form.

_____ Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____ Signature of witness number 2

Block B Notarization

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

_____ Signature of Notary Public

Approved by Tennessee Department of Health. Board for Licensing Health Care Facilities, February 3, 2005