Rodney Haun
Attorney At Law

Durable Medical Power of Health Care Questionnaire

Your information:

Client Name: _____

Address: _____

City: _____

(*spouse's entries follow on page 3)

1. Appointment of Attorney-in-Fact

Name: _____

Address: _____

City: _____

Relationship: _____

Alternative Agent:

Name: _____

Address: _____

City: _____

Relationship: _____

2. Medical decisions

My agent/ attorney-in-fact is authorized to make all medical decisions on my behalf except:

_____

_____

_____

_____

3. **Original and Copies:**

Where will you keep the original once signed: _____

_____

4. **To whom will you provide copies**? (Recommend your family doctor)

_____

_____

_____

5. **<u>Witness or Notary:</u>**

<u>Witness or Notary:</u>

If witness, you will need two people that are unrelated, not your attorney-in-fact for Health Care, not your physician or nurse at a facility that is treating you. Witnesses must be present at signing of the document.

A notary public is another option.

☐Two witness option ☐Notary Option

Durable Medical Power of Health Care Questionnaire

Spouse information:

Name: _____

Address: _____

City: _____

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Name: _____

Address: _____

City: _____

Relationship: _____

Alternative Agent:

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