~ Mississippi ~
Durable Power of Attorney For Health Care Christian Version

NOTICE 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 the attorney in fact (your agent) the power to make health care decisions for you. This power exists only as to those health care decisions to which you are unable to give informed consent. The attorney in fact must act consistently with your desires as stated in this document or otherwise made known.

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.

The 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 statement of your desires and 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 (a) authorizes anything that is illegal, (b) acts contrary to your known desires or (c) where your desires are not known and does anything that is clearly contrary to your best interests.

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

Your agent has the right to examine your medical records and to consent to this 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 (a) authorize an autopsy, (b) donate your body or parts thereof for transplant or for education, therapeutic, or scientific purposes, and (c) direct the disposition of your remains.

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

This durable power of attorney will not be valid for making health care decisions unless it is either (a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature or (b) acknowledged before a notary public in the state.

STATE OF MISSISSIPPI
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

Written in accordance with Mississippi Code §§ 41-41-201 to 41-41-229

Document made this _____ day of _____, _____.
Month Year

DESIGNATION OF AGENT

I designate the following individual as my agent to make health care decisions for me:

_____, _____,
Name of individual you choose as agent Street

_____, _____, _____, (_____) _____, (_____) _____
City State Zip Code Home Phone Work Phone

DESIGNATION OF ALTERNATE AGENTS

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____, _____,
Name of individual you choose as first alternate agent Street

_____, _____, _____, (_____) _____, (_____) _____
City State Zip Code Home Phone Work Phone

If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____, _____,
Name of individual you choose as second alternate agent Street

_____, _____, _____, (_____) _____, (_____) _____
City State Zip Code Home Phone Work Phone

AGENT'S AUTHORITY

Unless I have specified otherwise in this document, my agent is authorized to make all health care decisions for me, before or after my death, to the same extent as I could make health care decisions for myself if I had the capacity to do so, including making a disposition under the state's anatomical gift act; authorizing an autopsy; and directing the disposition of remains. I have discussed my desires thoroughly with my agent and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my agent under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my agent is instructed to make the health care decision for me, but my agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my agent shall base his or her health care decision on what he or she believes to be in my best interest.

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

☐ **If I mark this box, my agent's authority to make health care decisions for me takes effect immediately.**

AGENT'S OBLIGATION

My agent shall make health care decisions for me in accordance with this durable power of attorney for health care, any instructions I give in this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

NOMINATION OF GUARDIAN

If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonable available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PRIMARY PHYSICIAN

Optional

I designate the following physician as my primary physician:

_____, _____,
Name of physician Street

_____, _____, _____, (_____) _____, (_____) _____
City State Zip Code Home Phone Work Phone

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician (optional):

_____, _____,
Name of physician Street

_____, _____, _____, (_____) _____, (_____) _____
City State Zip Code Home Phone Work Phone

EFFECT OF COPY

A copy of this form has the same effect as the original.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My agent may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

HIPAA RELEASE STATEMENT

I intend for my health care agent to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my agent the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

ADMISSION TO NURSING HOMES

My agent may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my agent may not so admit me:

A nursing home **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 8-11)

If I have not checked either "Yes" or "No" immediately above, my agent may only admit me for short–term stays for recuperative care or respite care.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my agent may not have a feeding tube withheld or withdrawn from me.

My agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 8-11)

If I have not checked either "Yes" or "No" immediately above, my agent may not have a feeding tube withheld or withdrawn from me.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my agent may not make health care decisions for me if my agent knows I am pregnant.

Health care decision if I am pregnant **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 8-11)

If I have not checked either "Yes" or "No" immediately above, my agent may not make health care decisions for me if he or she knows I am pregnant.

In no event is my agent authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state (add more items as appropriate):

1. I request that the attached Addendum (pages 8-11) be included as a valid part of this Durable Power of Attorney for Health Care document.

2. I request, but not as a requirement, that my agent consult my clergy regarding health care decisions.

3. _____

_____

_____

_____

_____

_____

[Attach additional pages, if needed]

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my agent has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

The principal and the witnesses or notary public must sign the document at the same time.

SIGNATURE OF PRINCIPAL

(Person creating this Durable Power of Attorney for Health Care)

Signature: _____ Date: _____

Print Name: _____

Address: _____

(The signing of this document by the principal revokes all previous durable power of attorney for health care documents.)

STATEMENT OF WITNESSES

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Witness #1

Print name: _____ Date: _____

Address: _____

Signature: _____

Witness #2

Print name: _____ Date: _____

Address: _____

Signature: _____

OR

State of Mississippi

County of _____

On this _____ day of _____, in the year _____, before me, _____
Name of Notary Public

appeared _____, personally known to me (or proved to me on the basis of
Name of Principal

satisfactory evidence) to be the person whose name is subscribed to this instrument and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

NOTARY SEAL

_____
Signature of Notary Public

STATEMENT OF HEALTH CARE AGENT

I understand that _____ has designated me to be his or her health care agent
Name of principal
if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Agent's signature: _____

Address: _____

STATEMENT OF ALTERNATE HEALTH CARE AGENT

I understand that _____ has designated me to be his or her alternate
Name of principal
health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care agent is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Alternate agent's signature: _____

Address: _____

ANATOMICAL GIFTS
Optional

Upon my death:

_____ I wish to donate only the following organs or parts:

_____

_____

_____

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: _____ Date: _____

ADDENDUM TO THE STATE OF MISSISSIPPI DURABLE POWER OF ATTORNEY FOR HEALTH CARE

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief in the inherent value of human life and that life is a gift from God. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my health care agent to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My health care agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care agent to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My health care agent may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my health care agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I have checked "Yes" to the "Withhold or withdraw a feeding tube" option in the "PROVISION OF FEEDING TUBE" section of the Power of Attorney for Health Care Document, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

The principal and the witnesses or notary public must sign the document at the same time.

SIGNATURE OF PRINCIPAL

(Person creating this Durable Power of Attorney for Health Care)

Signature: _____ Date: _____

Print Name: _____

Address: _____

(The signing of this document by the principal revokes all previous durable power of attorney for health care documents.)

STATEMENT OF WITNESSES

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Witness #1

Print name: _____ Date: _____

Address: _____

Signature: _____

Witness #2

Print name: _____ Date: _____

Address: _____

Signature: _____

OR

State of Mississippi

County of _____

On this _____ day of _____, in the year _____, before me, _____
Name of Notary Public

appeared _____, personally known to me (or proved to me on the basis of
Name of Principal

satisfactory evidence) to be the person whose name is subscribed to this instrument and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

NOTARY SEAL

_____
Signature of Notary Public

STATEMENT OF HEALTH CARE AGENT

I understand that _____ has designated me to be his or her health care agent
Name of principal
if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Agent's signature: _____

Address: _____

STATEMENT OF ALTERNATE HEALTH CARE AGENT

I understand that _____ has designated me to be his or her alternate
Name of principal
health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care agent is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Alternate agent's signature: _____

Address: _____

CLERGY
Optional

The principal has requested that the agent consult me, as the principal's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the agent to help meet the directives as described in this Power of Attorney for Health Care document and attached Addendum.

Clergy's signature: _____ Phone: (_____) _____

Church address: _____

I have given copies of this Durable Power of Attorney for Health Care – Christian Version to:

_____

_____

_____

_____

_____

_____