Appointment of Health Care Representative

I, _____, voluntarily appoint the following person as my health care representative to act on my behalf in all matters of health care in accordance with Indiana Code 16-36-1 and Indiana Code 30-5 *et seq.*, as they exist now and may be amended in the future. In the event I am incapable of consenting to health care, I appoint the following:

_____ *[insert name]*
_____ *[insert address]*
_____ *[insert telephone #'s]*

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care; provided, however, that my health care representative shall (i) consider that management of pain is very important to me, and (ii) keep me comfortable and free of pain as possible. If, at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss any decisions with me; however, if I am unable to communicate, my representative may make decisions for me, after consultation with my physician(s) and other relevant caregiver(s). To the extent appropriate, my representative may also discuss any decisions with my family and others to the extent they are available. My representative shall, however, have priority and complete authority to act in all matters pertaining to my health care, unless I am capable of consenting.

Health Information: When I am unable to manage my own affairs, the authority given to my health care representative includes the authority to receive information about my health conditions and to request to view or obtain copies of my health care records (which may include mental health records and substance abuse records.)

This authority given to my health care representative has no expiration date and shall expire only in the event that I revoke this authority in writing and deliver it to my health care provider.

This appointment is to be exercised in good faith and in my best interest. This appointment becomes effective and remains effective if I am incapable of consenting to my own health care. I do authorize my health care representative hereby appointed to delegate decision-making power to another individual.

Dated this _____ day of _____, 20__.

_____ _____
Signature *Street Address*

_____ _____
Printed name *City, State*

I, declare that I am an adult at least eighteen (18) years of age or older and that at the request of the above-named individual making the appointment, I witnessed the signing of this document by said individual on the date noted above.

_____ _____
Signature of Witness *Street Address*

_____ _____
Printed Name of Witness *City, State*