Advance Directive Form

NOTE: This form is being provided to you as a public service. The attached forms are provided "as is" and are not the substitute for the advice of an attorney. By providing these forms and information, Everplans is not providing legal advice to you. Consult an attorney if you need legal advice of any nature.

Read more and get more forms at Everplans' Advance Directive page.

Durable Power of Attorney for Health Care: Kansas

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, hereby appoint the following person as my attorney-in-fact for health care decisions:

Name: _____

Address: _____

City / State / Zip: _____

Phone: _____

In the event the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my health care agent, I hereby appoint the following person as alternate attorney-in-fact.

Name: _____

Address: _____

City / State / Zip: _____

Phone: _____

This is a durable power of attorney, and the authority of my attorney-in-fact shall not terminate if I become disabled or in the event of later uncertainty as to whether I am alive or dead. This durable power of attorney shall become effective immediately. This authority shall not include the ability to revoke or invalidate any declaration made in accordance with the Natural Death Act (a “Living Will” or similarly-titled document).

My attorney-in-fact shall have the authority to, on my behalf:

1. Consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, and to make decisions about organ donation, autopsy, and disposition of the body.

2. Make any and all arrangements at any hospital, psychiatric hospital, or psychiatric treatment facility, hospice, nursing home, or similar institution in Kansas or any other state or country; make arrangements for my release and removal from any institution; employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists, or any other person who is licensed, certified, authorized, or permitted by law to administer health care, as the agent shall deem necessary for my physical, mental, and emotional well-being;

3. Request, receive, and review any verbal or written information regarding my personal affairs or physical or mental health, including medical and hospital records, to execute any releases that may be required to obtain this information, and to consent to the disclosure of this information. I

hereby waive my patient-physician privileges in relation to this Durable Power of Attorney for Health Care Decisions. Further, I hereby knowingly and purposefully waive any and all rights I may now have and in the future under the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, and the Department of Health and Human Services (HHS) Privacy Rule of 2000 (Standards for Privacy of Individually Identifiable Health Information) and thereby allow my doctors and all other health care providers, health care plans and clearinghouses, including the medical staff and short term medical facilities, to release all information regarding my medical history, status, diagnosis and treatment to my attorney and agent herein setout.

I hereby revoke any previous Durable Power of Attorney for Health Care Decisions. This revocation does not extend to any previous General Durable Power of Attorney. I reserve the right to revoke this document by subsequent writing executed in the same manner as this document. This document shall continue in full effect until the earlier of the following: (1) my death; or (2) my revocation of this document.

Signed this _____ day of _____, 20_____

Signature: _____

THIS POWER OF ATTORNEY DIRECTIVE MUST BE SIGNED BY TWO WITNESSES AND/OR A NOTARY PUBLIC.

I believe the above declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am at least eighteen (18) years of age and am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession of this state or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician.

Witness Signature: _____

Print Full Name: _____

Date: _____

Address: _____

City / State / Zip: _____

Witness Signature: _____

Print Full Name: _____

Date: _____

Address: _____

City / State / Zip: _____

STATE OF KANSAS, COUNTY OF _____

The foregoing Durable Power of Attorney for Health Care was acknowledged before me

this _____ day of _____, 20_____, by _____ (the declarant).

_____ Notary Public

_____ My Commission Expires

Living Will: Kansas

LIVING WILL

Declaration made this day _____ of _____, 20____.

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration. Any Living Will declaration I have previously made is hereby revoked.

Signed this _____ day of _____, 20_____

Signature: _____

Address: _____

City / State / Zip: _____

Phone: _____

Living Will: Kansas

THIS LIVING WILL MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC.

The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care.

Witness: _____ Address: _____

Witness: _____ Address: _____

STATE OF KANSAS, COUNTY OF _____

The foregoing Durable Power of Attorney for Health Care was acknowledged before me

this _____ day of _____, 20____, by _____ (the declarant).

_____ _____

Notary Public My Commission Expires