Durable Health Care Power of Attorney

STATE OF LOUISIANA PARISH OF ______________________________

BEFORE ME, the undersigned Notary, and in the presence of the undersigned competent witnesses, came ____ a resident of the full age of majority of ________________________________ Parish, referred to herein as "Principal", who appoints ____a resident of the full age of majority of ______________________________ Parish, as Agent. Agent accepts and agrees to be bound by this specific Power of Attorney.

I. When This Power of Attorney Takes Effect

(Choose one or the other and check ONLY one)

____ My agent can start acting for me as soon as I sign this Power of Attorney.

____ My agent can only start acting for me when I can't let others know what I want.

II. My Agent's Powers

I give my agent all the powers below which are checked "YES", regarding the health care matters that I could exercise on my own behalf. My agent may:

YES NO

____ ____ **Medical Records.** Have access to any medical information in any form about my physical or mental condition, and give or sign any consent forms needed to get it.

____ ____ **Professionals.** Hire, pay and fire any health care professionals my Agent thinks necessary to examine, evaluate or treat me, whether it is for emergency, elective, recuperative, convalescent or other kind of care.

____ ____ **Institutionalization.** Admit me to any health care facility recommended by a qualified health care professional, whether for physical or mental care or treatment, and remove me from such facility at any time, even if against medical advice.

____ ____ **Treatment.** Consent to tests, treatment, medication, surgery, organ transplant or other procedures, and to cancel that consent, even if against medical advice.

____ ____ **Chemical dependency.** Consent to a course of treatment for chemical dependency, whether suspected or diagnosed, and revoke that consent.

____ ____ **Pain Relief.** Consent to pain relief procedures, even if they are unconventional or experimental, even if their use may risk addiction, injury or shorten my life.

____ ____ **Releases.** Release from liability any health care professional or institution that acts on behalf of me in reliance on my Agent.

III. Third Parties

To protect others who deal with my Agent under powers given in this Power of Attorney, people may rely on my Agent's act or signature with the same force and effect as though I were personally present and acting for myself on my behalf, accordingly:

Notice of Amendment or Revocation. No one dealing with my Agent is responsible for knowing I have changed or cancelled this Power of Attorney until a copy of the new Power of Attorney or written notice of the cancellation is delivered to them.

Reliance. Until they receive actual notice that this agency has been changed or cancelled, people may assume that my Agent is acting within the scope of the powers I have given in this Power of Attorney, and that it is still in effect. No one who deals with my Agent is responsible for my Agent's proper use of funds or property.

Information. If asked for information about me, people may give it to my Agent. I release them from any and all legal liability for giving the information my Agent asks for. If that information is privileged, I waive the privilege. My Agent may share that information with whoever my Agent thinks appropriate.

Binding Effect of Copies. People may act on any copy of this Power of Attorney just as if it were the original.

THUS DONE AND SIGNED on this ______ day of ________________________________, 20_______.

______________________________	______________________________
Witness	Principal
______________________________	______________________________
Witness	Agent

____

NOTARY PUBLIC
Louisiana Notary # ________________
My commission expires on: __________