

DURABLE POWER OF
ATTORNEY / WITH HEALTH
CARE POWERS ONLY
AND
OKLAHOMA DNR CONSENT FORM

WHAT IS A DURABLE POWER OF ATTORNEY

- Living for today doesn't mean you can't prepare for the future. Whether you're at risk of becoming ill or just planning ahead, it's a good idea to create a durable power of attorney. It authorizes someone you trust to be in charge of your decisions should you become seriously ill or incapacitated, and makes others aware of your wishes.

POA CONT.

- ◉ POA for finances: Gives a designated person the authority to make legal/financial decisions on behalf of the person.



POA CONT.

- ◎ Families should prepare these legal documents long before someone starts having trouble handling certain aspects of life. At the time of the signing, the elderly person establishing a durable power of attorney must be capable of deciding to seek assistance. For example, people in late stages of Alzheimer's disease may not be "of sound mind" and therefore unable to appoint a POA

- ◉ Like a trust, a durable power of attorney can be written so that the transfer of responsibilities occurs immediately. Or, the POA can state that the POA goes into effect when your elderly parent becomes incapacitated. Until that point, the elder can choose to continue to make decisions on his/her own.



POA CONT.

- ⦿ The next few slides is an example of a legal POA document.



CONTINUED

DURABLE POWER OF ATTORNEY

I, _____ (your name), of the City of _____, County of _____, State of Oklahoma, do hereby execute this Durable Power of Attorney with the intention that the Attorney-in-fact hereinafter named shall be able to act in my place in all matters.

I constitute and appoint _____, to be my Attorney-in-fact for me, in my name, and in my place. If he/she is unable or unwilling to serve then I name _____, to so act on my behalf.

This Power of Attorney shall become effective EITHER _____ Immediately and remain in effect upon my disability or incapacity (please place your initial on the line if you choose this option) OR _____ become effective upon my disability or incapacity (please place your initial on the line if you choose this option). I shall be presumed to be disabled or incapacitated (and this Durable Power of Attorney shall become effective) upon presentation of a notarized statement to that effect from (a) My regular physician, _____ or (b) two other physicians selected by my Attorney-in-fact.

This Power of Attorney shall not be affected by my subsequent disability or incapacity, and it is my intention that this Power of Attorney be governed by the Uniform Durable Power of Attorney Act Oklahoma Statutes, Title 58, §§ 1071 *et seq.*

I grant my Attorney-in-fact the following powers:

TO GRANT ONE OR MORE, BUT FEWER THAN ALL, OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF EACH POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF IT. YOU MAY, BUT NEED NOT, CROSS OUT EACH POWER WITHHELD.

INITIAL

- _____ (A) Real property transactions.
- _____ (B) Tangible personal property transactions.
- _____ (C) Stock and bond transactions
- _____ (D) Commodity and option transactions.
- _____ (E) Banking and other financial institution transactions.

CONTINUED

- _____ (F) Business operating transactions.
- _____ (G) Insurance and annuity transactions.
- _____ (H) Estate, trust, and other beneficiary transactions.
- _____ (I) Claims and litigation
- _____ (J) Personal and family maintenance
- _____ (K) Benefits from Social Security, Medicare, Medicaid, or other governmental programs, or military service.
- _____ (L) Retirement plan transactions.
- _____ (M) Tax matters.
- _____ (N) ALL OF THE POWERS LISTED ABOVE. YOU NEED NOT INITIAL ANY OTHER LINES IF YOU INITIAL THIS LINE

HIPAA Release Authority. I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (a/k/a HIPAA), 42 USC 1320d and 45 CFR 160-164. I authorize:

any physician, health care provider, any insurance company and the Medical Information Bureau Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services,

to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

The authority given my agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

SPECIAL INSTRUCTIONS:

ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS GRANTED TO YOUR AGENT.

CONTINUED

(Attach additional pages if needed.)

And generally, to do all acts and take all steps which in the Attorney-in-fact's judgment are necessary, convenient, or expedient in the management of my property and affairs, hereby giving my said attorney full power to act for me and in relation to my affairs, business, and property as fully and with like effect as I could act as if personally present. Hereby ratifying and confirming all the acts of my said attorney done by virtue and in pursuance of these presents.

Signed: _____ Date: _____

_____, Principal (your name)

City, County and State of Residence: City of _____, County of _____, State of Oklahoma
Oklahoma

The principal is personally known to me and I believe the principal to be of sound mind. I am eighteen (18) years of age or older. I am not related to the principal by blood or marriage, or related to the attorney-in-fact by blood or marriage. The principal has declared to me that this instrument is his power of attorney granting to the named attorney-in-fact the power and authority specified herein, and that he/she has willingly made and executed it as his free and voluntary act for the purposes herein expressed.

Witness: _____

Address: _____

Witness: _____

Address: _____

CONTINUED

STATE OF OKLAHOMA)
) ss.
COUNTY OF _____)

Before me, the undersigned authority, on this ____ day of _____, 20____, personally appeared _____ (your name as Principal), _____, (Witness) and _____ (Witness), whose names are subscribed to the foregoing instrument in their respective capacities, and all of said persons being by me duly sworn, the principal declared to me and to the said witnesses in my presence that the instrument is his or her power of attorney, and that the principal has willingly and voluntarily made and executed it as the free act and deed of the principal for the purposes therein expressed, and the witnesses declared to me that they were each eighteen (18) years of age or over, and that neither of them is related to the principal by blood or marriage, or related to the attorney-in-fact by blood or marriage.

NOTARY PUBLIC

My Commission Expires: _____ My Commission Number is: _____

POA WITH HEALTH CARE ONLY

- You name a trusted person to oversee your medical care and make health care decisions for you if you are unable to do so. Depending on where you live, the person you appoint may be called your "agent," "attorney-in-fact," "health care proxy," "health care surrogate," or something similar.



HEALTH CARE CONT.

- ◎ Your health care agent will work with doctors and other health care providers to make sure you get the kind of medical care you wish to receive. When arranging your care, your agent is legally bound to follow your treatment preferences to the extent that he or she knows about them.

HEALTH CARE CONT.

- ◎ To make your wishes clear, you can use a second type of health care directive -- often called a "health care declaration" or "living will" -- to provide written health care instructions to your agent and health care providers. To make this easier, some states combine a durable power of attorney for health care and health care declaration into a single form, commonly called an "advance health care directive."

HEALTH CARE CONT.

- The next few slides are a legal POA for health care.



HEALTH CARE CONT.

DURABLE POWER OF ATTORNEY (WITH HEALTH CARE POWERS ONLY)

NOTICE: The powers granted by this document are broad and sweeping. They are explained in the Uniform Statutory Form Power of Attorney Act. If you have any questions about these powers, obtain competent legal advice. Free legal information regarding construction of the powers granted by this document and completion of this form may be obtained by calling the Legal Services Developer, Aging Services Division of the Oklahoma Department of Human Services, (405) 522-3069, or your local legal aid or legal services office. This document authorizes your agent to make medical and other health-care decisions for you. You may revoke this power of attorney if you later wish to do so.

I _____
(insert name and address)

appoint _____
(insert name and address of the person appointed)

as my agent (attorney-in-fact) to act for me in any lawful way with respect to the following initialed subjects.
If my agent is unable or unwilling to serve, I appoint _____

_____ (insert name and address)
as my alternate agent with the same authority.

Once effective pursuant to section III on the back of this form, this power of attorney will continue to be effective even though I become disabled, incapacitated, or incompetent, and shall not be affected by lapse of time.

I. Grant of Health Care Powers

To grant all of the following powers, initial the line in front of (f) and ignore the lines in front of the other powers.

To grant one or more, but fewer than all, of the following powers, initial the line in front of each power you are granting.

To withhold a power, do not initial the line in front of it. You may, but need not, cross out each power withheld.

1. If I am unable to decide or speak for myself, my agent has the power to:

Initial

- _____ a. Make health and medical care decisions for me, including serving as my representative under the Oklahoma Do-Not-Resuscitate Act, but excluding signing an advance directive, making decisions reserved to a health care proxy under an advance directive, or other life-sustaining treatment decisions.
- _____ b. Choose my health care providers.
- _____ c. Choose where I live and receive care and support when these choices relate to my health care needs.
- _____ d. Review my medical records and have the same rights that I would have to give my medical records to other people.
- _____ e. Elect hospice treatment.
- _____ f. All of the powers listed above.

You need not initial any other lines if you initial line f.

2. It is my intention that my agent's acts on my behalf are to be honored by my family members and health care providers as an expression of my legal right to manage my health care. The directions and decisions of my agent are superior to and shall take precedence over any decision made by any member of my family. To the extent appropriate, my agent may discuss health care decisions with my family and others to the extent they are available.

II. Additional Guidance and Information

NOTE: This section, while very helpful to your agent, is optional and choices may be left blank.

a. My goals for my health care: _____

b. My fears about my health care: _____

c. My spiritual or religious beliefs and traditions: _____

d. My thoughts about how my medical condition might affect my family: _____

e. My thoughts about living and receiving health care at home versus in a nursing home or other institution: _____

Special Instructions: On the following lines you may give special instructions limiting or extending the powers granted to your agent. _____

(Attach additional pages if needed.)

III. When Power Becomes Effective

Please initial one statement below regarding the effective date of this power of attorney.

Initial

_____ This power of attorney is effective immediately and shall continue until it is revoked.

_____ This power of attorney shall be effective when my attending physician determines that I am no longer able to manage my person. This determination shall be provided in writing and attached to this form.

I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party learns of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

Signed: _____

(Principal's signature)

City, County, and State of Residence _____

The principal is personally known to me and I believe the principal to be of sound mind. I am eighteen (18) years of age or older. I am not related to the principal by blood or marriage, or related to the attorney-in-fact by blood or marriage. The principal has declared to me that this instrument is his power of attorney granting to the named attorney-in-fact the power and authority specified herein, and that he has willingly made and executed it as his free and voluntary act for the purposes herein expressed.

Witness: _____

Witness: _____

STATE OF OKLAHOMA)

) SS.

COUNTY OF _____)

Before me, the undersigned authority, on this _____ day of _____, 20____, personally appeared _____ (principal), _____ (witness), and _____ (witness), whose names are subscribed to the foregoing instrument in their respective capacities, and all of said persons being by me duly sworn, the principal declared to me and to the said witnesses in my presence that the instrument is his or her power of attorney, and that the principal has willingly and voluntarily made and executed it as the free act and deed of the principal for the purposes therein expressed, and the witnesses declared to me that they were each eighteen (18) years of age or over, and that neither of them is related to the principal by blood or marriage, or related to the attorney-in-fact by blood or marriage.

Notary Public

My Commission Expires: _____

By accepting or acting under the appointment, the agent assumes the fiduciary and other legal responsibilities of an agent.



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WHAT IS A DNR?

- ◉ Do not resuscitate (DNR), also known as no code or allow natural death, is a legal order written either in the hospital or on a legal form to withhold cardiopulmonary resuscitation (CPR) or advanced cardiac life support (ACLS), in respect of the wishes of a patient in case their heart were to stop or they were to stop breathing. "No code" is a reference to the use of "code" as jargon for "calling in a Code Blue" to alert a hospital's resuscitation team.

DNR CONT.

- ◉ In the United States the documentation is especially complicated in that each state accepts different forms, and advance directives and living wills are not accepted by EMS as legally valid forms. If a patient has a living will that specifies the patient requests to be DNR but does not have a properly filled out state sponsored form that is co-signed by a physician, EMS will attempt resuscitation.

DNR CONT.

- The DNR decision by patients was first litigated in 1976 in In re Quinlan. The New Jersey Supreme Court upheld the right of Karen Ann Quinlan's parents to order her removal from artificial ventilation.
- In 1991 Congress passed into law the Patient Self-Determination Act that mandated hospitals honor an individual's decision in their healthcare. Forty-nine states currently permit the next of kin to make medical decisions of incapacitated relatives, the exception being Missouri.
- Missouri has a Living Will Statute that requires two witnesses to any signed advance directive that results in a DNR/DNI code status in the hospital

OKLAHOMA DONOTRESUSCITATE (DNR) CONSENT FORM

- I, _____, request limited health care as described in this document. If my heart stops beating or if I stop breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider including, but not limited to, emergency medical services (EMS) personnel.
- I understand that this decision will not prevent me from receiving other health care such as the Heimlich maneuver or oxygen and other comfort care measures.
- I understand that I may revoke this consent at any time in one of the following ways:

CONT.

- ① 1. If I am under the care of a health care agency, by making an oral, written, or other act of communication to a physician or other health care provider of a health care agency;
- ② 2. If I am not under the care of a health care agency, by destroying my donotresuscitate form, removing all donotresuscitate identification from my person, and notifying my attending physician of the revocation;
- ③ 3. If I am incapacitated and under the care of a health care agency, my representative may revoke the donotresuscitate consent by written notification to a physician or other health care provider of the health care agency or by oral notification to my attending physician; or
- ④ 4. If I am incapacitated and not under the care of a health care agency, my representative may revoke the donotresuscitate consent by destroying the donotresuscitate form, removing all donotresuscitate identification from my person, and notifying my attending physician of the revocation.

CONT.

- ⊙ I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers.
- ⊙ I hereby state that I am making an informed decision and agree to a donotresuscitate order. Signature of Person or Signature of Representative (Limited to an attorneyin fact for health care decisions acting under the Durable Power of Attorney Act, a health care proxy acting under the Oklahoma Advance Directive Act or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act.)
- ⊙ This DNR consent form was signed in my presence.
Date Signature of Witness Address Signature of Witness A

CONT.

- CERTIFICATION OF PHYSICIAN
- This form is to be used by an attending physician only to certify that an incapacitated person without a representative would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. An attending physician of an incapacitated person without a representative must know by clear and convincing evidence that the incapacitated person, when competent, decided on the basis of information sufficient to constitute informed consent that such person would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Clear and convincing evidence for this purpose shall include oral, written, or other acts of communication between the patient, when competent, and family members, health care providers, or others close to the patient with knowledge of the patient's desires.

CONT.

- ⦿ I hereby certify, based on clear and convincing evidence presented to me, that I believe that Name of Incapacitated would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Therefore, in the event of cardiac or respiratory arrest, no chest compressions, artificial ventilation, intubations, defibrillation, or emergency cardiac medications are to be initiated.
- ⦿ Physician's Signature
- ⦿ Physician's Name (PRINT)
- ⦿ Physician's Address/Phone
- ⦿ Date
- ⦿ This DNR consent form and Certification of Physician is copied from Senate Bill 1325.
- ⦿ This law is effective November 1, 2010.

○ ANY QUESTION AT THIS TIME?

