LITHERLAND, KENNEDY & ASSOCIATES, APC

HEALTH CARE POWER OF ATTORNEY—FOR YOUNG ADULTS

NAME: _____ **PHONE:** _____

ADDRESS: _____

EMAIL: _____

AGENT CHOICE:

1. _____ Relationship to you: _____
2. _____ Relationship to you: _____
3. _____ Relationship to you: _____
4. _____ Relationship to you: _____

WHAT ARE YOUR END-OF-LIFE DECISIONS?

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

_____**(a) Choice Not To Prolong Life**
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, **OR**

_____ **(b) Choice To Prolong Life**
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

WHAT ARE YOUR WISHES REGARDING DONATION OF ORGANS UPON YOUR DEATH:

Upon my death (mark applicable box): By checking (a) or (b), below, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedure necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation

_____ (a) I give any needed organs, tissues, or parts, OR

_____ (b) I give the following organs, tissues, or parts only. _____

_____ (c) My gift is for the following purposes (Initial any of the following that you do want):

(1) Transplant _____
(2) Therapy _____
(3) Research _____
(4) Education _____

_____ (d) I do NOT want any organs, tissues or parts donated.

ARE THERE ANY OTHER WISHES YOU WANT TO HAVE KNOWN?

_____

_____