

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENT OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE CONSENT, REFUSAL OF CONSENT OR WITHDRAWAL OF CONSENT TO ANY CARE, TREATMENT, SERVICE OR PROCEDURE TO MAINTAIN, DIAGNOSE OR TREAT A PHYSICAL OR MENTAL CONDITION. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT OR PLACEMENTS THAT YOU DO NOT DESIRE.

2. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.

3. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THE POWER OF THE PERSON YOU DESIGNATE TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT WHICH WOULD KEEP YOU ALIVE.

4. UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST INDEFINITELY FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

5. NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED IF YOU OBJECT.

6. YOU HAVE THE RIGHT TO REVOKE THE APPOINTMENT OF THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THAT PERSON OF THE REVOCATION ORALLY OR IN WRITING.

7. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY GRANTED TO THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THE TREATING PHYSICIAN, HOSPITAL OR OTHER PROVIDER OF HEALTH CARE ORALLY OR IN WRITING.

8. THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

9. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

10. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

1. DESIGNATION OF HEALTH CARE AGENT.

I,,
(insert your name) do hereby designate and appoint:

Name:

Address:

Telephone Number:

as my agent to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish to designate as your agent to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your agent: (1) your treating provider of health care; (2) an employee of your treating provider of health care; (3) an operator of a health care facility; or (4) an employee of an operator of a health care facility.)

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED.

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the agent named above full power and authority: to make health care decisions for me before or after my death, including consent, refusal of consent or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition; to request, review and receive any information, verbal or written, regarding my physical or mental health, including, without limitation, medical and hospital records; to execute on my behalf any releases or other documents that may be required to obtain medical care and/or medical and hospital records, EXCEPT any power to enter into any arbitration agreements or execute any arbitration clauses in connection with admission to any health care facility including any skilled nursing facility; and subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS.

(Your agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization or abortion. If there are any other types of treatment or placement that you do not want your agent's authority to give consent for or other restrictions you wish to place on his or her agent's authority, you should list them in the space below. If you do not write any limitations, your agent will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, the authority of my agent is subject to the following special provisions and limitations:

5. DURATION.

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this power of attorney end on the following date:

6. STATEMENT OF DESIRES.

(With respect to decisions to withhold or withdraw life-sustaining treatment, your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your agent has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)

(If the statement reflects your desires, initial the box next to the statement.)

1. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures. []

2. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.)
[.....]

3. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not

be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.) []

4. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastrointestinal tract after all other treatment is withheld..... []

5. I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My agent is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life. []

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Other or Additional Statements of Desires:.....

7. DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate any alternative agent but you may do so. Any alternative agent you designate will be able to make the same health care decisions as the agent designated in paragraph 1, page 2, in the event that he or she is unable or unwilling to act as your agent. Also, if the agent designated in paragraph 1 is your spouse, his or her designation as your agent is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my agent is unable to make health care decisions for me, then I designate the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternative Agent

Name:
Address:
Telephone Number:

B. Second Alternative Agent

Name:
Address:
Telephone Number:

8. PRIOR DESIGNATIONS REVOKED.

I revoke any prior durable power of attorney for health care.

9. WAIVER OF CONFLICT OF INTEREST.

If my designated agent is my spouse or is one of my children, then I waive any conflict of interest in carrying out the provisions of this Durable Power of Attorney for Health Care that said spouse or child may have by reason of the fact that he or she may be a beneficiary of my estate.

10. CHALLENGES.

If the legality of any provision of this Durable Power of Attorney for Health Care is questioned by my physician, my agent or a third party, then my agent is authorized to commence an action for declaratory judgment as to the legality of the provision in question. The cost of any such action is to be paid from my estate. This Durable Power of Attorney for Health Care must be construed and interpreted in accordance with the laws of the State of Nevada.

11. NOMINATION OF GUARDIAN.

If, after execution of this Durable Power of Attorney for Health Care, incompetency proceedings are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court my agent herein named, in the order named.

12. RELEASE OF INFORMATION.

I agree to, authorize and allow full release of information by any government agency, medical provider, business, creditor or third party who may have information pertaining to my health care, to my agent named herein, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended, and applicable regulations.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Durable Power of Attorney for Health Care on
.....(date) at (city), (state)

(Signature)

(THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of the statement of witnesses.)

State of Nevada }
 } ss.
County of.....}

On this..... day of....., in the year....., before me,..... (here insert name of notary public) personally appeared..... (here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

NOTARY SEAL

.....
(Signature of Notary Public)

STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the agent; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; or (5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document and that I am not a provider of health care, an employee of a provider of health care, the operator of a community care facility or an employee of an operator of a health care facility.

Signature: Residence Address:
Print Name:
Date:

Signature: Residence Address:
Print Name:
Date:

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption and that to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature:

Signature:

Names: Address:.....
Print Name:
Date:

COPIES: You should retain an executed copy of this document and give one to your agent. The power of attorney should be available so a copy may be given to your providers of health care.

(Added to NRS by 2009, 201; A 2013, 926)

Informational Brochure



POWER OF ATTORNEY FORMS

What is a power of attorney?

A power of attorney is your legal permission for another adult to act on your behalf. The permission can be granted for a specific, limited purpose and period of time or for much broader purposes (such as handling all of your financial affairs) and an unquantified period of time (such as until your death). The first type is called a "conventional power of attorney," and the second type is called a "durable power of attorney."

When would I want to give someone my power of attorney?

If you are going on an extended vacation and there are financial transactions that will need to be completed during that time (for instance, buying or selling a house, closing a mortgage, or buying or selling stock), it might be convenient or necessary to have an "attorney in fact" who can complete those transactions for you. Similar reasoning applies if you know you will be away on military duty. Another important use for a power of attorney is if you become incapacitated. Establishing a power of attorney in advance allows you to plan for who will be making decisions that affect your legal, financial and/or medical well-being.

Who can I name as my attorney in fact?

The person who holds your power of attorney is called your attorney in fact. Your "attorney in fact," in effect, steps into your shoes for the decisions you authorize that person to make. The attorney in fact must be an adult and must have the legal ability to enter into a contract. The person you choose can be (but does not have to be) a relative of yours. The person you name as attorney in fact should be someone you trust. You should also have that person's agreement to act as your attorney in fact before naming them, since acting as an attorney in fact is voluntary and no one can be required to serve as your attorney in fact.

The person who agrees to act as your attorney in fact will owe you a fiduciary duty, which means that your best interests must always be placed first while acting as your attorney in fact. The attorney in fact does not have to be compensated, but, especially if the duties are complicated or time-consuming, you may wish to consider compensation.



What is a durable power of attorney?

A durable power of attorney is designed for use in case you become incapacitated (such as through illness or by accident) and are no longer able to make decisions for yourself. The regular durable power of attorney becomes effective when it is signed and notarized. A "springing" durable power of attorney becomes effective on the day in the future that you become incapacitated. If you never become incapacitated, it does not become effective and your attorney in fact exercises no authority over you or your assets. Both types of durable power of attorney remain valid and in effect until you specifically revoke or cancel the power of attorney or until you die (and your attorney in fact can still act on your behalf until actual notice of your death is received). Both types of durable power of attorney allow your attorney in fact to deal with the financial and property matters you specify in the document. You may not want your attorney in fact to have authority over certain assets, such as a mutual fund you want to pass by will, or your house. *And remember, a power of attorney is not a substitute for a will. You still should have a will for the disposition of your property after you die.*

Where can I get power of attorney forms?

Your public library or county law library may have books with forms and instructions on how to prepare your own form. Office supply stores and financial institutions also may have forms available. You should be aware that a pre-printed form normally is intended for a specific purpose and that, if your purpose is more complex, you may wish to consult an lawyer. As always you should discuss your purpose and the cost of preparing your power of attorney with the lawyer up-front.

Over for more →

POWER OF ATTORNEY FORMS - (continued from other side)

⚖️ What is a durable power of attorney for health care?

The Nevada Legislature has enacted a specific law dealing with this type of power of attorney. Nevada Revised Statutes § 449.830 provides a specific form for durable power of attorney for health care decisions. The form allows you to give your attorney in fact broad authority to make health care decisions for you, including consent or refusal or withdrawal of consent for any care related to your physical or mental condition. The form also allows you to choose if you want life-prolonging treatments to be used if you are in a coma or have a terminal condition, or if you want artificial nutrition or hydration to be withheld. You are also allowed to designate alternate attorneys in fact. The statute containing the form is available at most public libraries. The form and the instructions it contains should be copied and followed exactly.

⚖️ Does a power of attorney have to be in writing and be notarized?

The power of attorney must be in writing and contain your signature to be effective. It may also – but need not be – notarized. The document may alternatively be witnessed by two adult witnesses who personally know you. However, neither of the witnesses may be any of the following: (a) a provider of health care; (b) an employee of a provider of health care; (c) an operator of a health care facility; (d) an employee of a health care facility; or (e) your attorney-in-fact. Moreover, at least one of the witnesses must be a person who is: (a) not related to you by blood, marriage, or adoption; and (b) to the best of the witnesses' knowledge, not entitled to any part of your estate upon your death. The original should be kept in a safe place. In the case of a "springing power of attorney" which becomes effective upon your incapacity in the future, the document must also be kept in a place that is accessible to the attorney in fact. For example, the attorney in fact may have no way of retrieving the document if it is in your safety deposit box.

⚖️ How should my attorney in fact sign documents of my behalf?

The signature should have your name followed by the name of the attorney in fact. For example: John Doe by Mary Roe, his attorney in fact.

⚖️ How can I revoke or cancel a power of attorney?

You can revoke a power of attorney by notifying your attorney in fact that you are revoking the power of attorney. You can use a simple one page form that states that you are revoking the power of attorney. The form should be signed by you and your signature should be notarized. If the power of attorney involves your incapacity, you may want to have witnesses also sign the revocation document. You should then deliver the revocation notice to the attorney in fact and deliver copies to any person or business to which the attorney in fact may have presented the power of attorney. Because Nevada law requires all power of attorney forms that allow the sale of real estate to be recorded (or if you recorded it for any other reason), you should also record the notice of revocation with your county recorder.

⚖️ How do I find an attorney with experience in Power of Attorney matters?

You can contact the State Bar of Nevada's **Lawyer Referral & Information Service** at **702-382-0504** (toll-free in Nevada at **1-800-789-5747**) or look in the yellow pages of your telephone directory. You can also ask friends and/or relatives if they can recommend a good lawyer. The State Bar's main office (see numbers listed below) can tell you whether or not an attorney is licensed in Nevada and in good standing.

Written and/or Edited by:

Ismail Amin, Amin Law Group – Las Vegas

State Bar of Nevada Las Vegas Office

600 E. Charleston Blvd., Las Vegas, NV 89104
Ph: 702-382-2200 or toll-free 1-800-254-2797
Fax: 702-385-2878 or toll-free 1-888-660-6767

Reno Office

9456 Double R Blvd., Suite B, Reno, NV 89521
Ph: 775-329-4100 Fax: 775-329-0522

<http://www.nvbar.org>



03/2010

*This brochure is a publication of the
State Bar of Nevada
Publications Committee*

**Contact: Christina Alberts
christinaa@nvbar.org**

This brochure is written and distributed for informational and public service purposes only and is not to be construed as legal advice.