

# State of Ohio

## Health Care Power of Attorney

[R.C. §1337]

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(Print Full Name)

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(Birth Date)

This is my Health Care Power of Attorney. I revoke all prior Health Care Powers of Attorney signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I understand that my agent can make health care decisions for me only whenever my attending physician has determined that I have lost the capacity to make informed health care decisions. However, this does not require or imply that a court must declare me incompetent.

### Definitions

**Adult** means a person who is 18 years of age or older.

**Agent or attorney-in-fact** means a competent adult who a person (the “principal”) can name in a Health Care Power of Attorney to make health care decisions for the principal.

**Artificially or technologically supplied nutrition or hydration** means food and fluids provided through intravenous or tube feedings. Any person can refuse or discontinue a feeding tube or authorize his or her Health Care Power of Attorney agent to refuse or discontinue artificial nutrition or hydration.

**Comfort care** means any measure, medical or nursing procedure, treatment or intervention, including nutrition and/or hydration, that is taken to diminish a patient’s pain or discomfort, but not to postpone death.

**CPR** means cardiopulmonary resuscitation, one of several ways to start a person’s breathing or heartbeat once either has stopped. It does not include clearing a person’s airway for a reason other than resuscitation.

**Do Not Resuscitate or DNR Order** means a physician’s medical order that is written into a patient’s record to indicate that the patient should not receive cardiopulmonary resuscitation.



**Health care** means any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental health.

**Health care decision** means giving informed consent, refusing to give informed consent, or withdrawing informed consent to health care.

**Health Care Power of Attorney** means a legal document that lets the principal authorize an agent to make health care decisions for the principal in most health care situations when the principal can no longer make such decisions. Also, the principal can authorize the agent to gather protected health information for and on behalf of the principal immediately or at any other time. A Health Care Power of Attorney is NOT a financial power of attorney.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

**Life-sustaining treatment** means any medical procedure, treatment, intervention or other measure that, when administered to a patient, mainly prolongs the process of dying.

**Living Will Declaration** means a legal document that lets a competent adult ("declarant") specify what health care the declarant wants or does not want when he or she becomes terminally ill or permanently unconscious and can no longer make his or her wishes known. It is NOT and does not replace a will, which is used to appoint an executor to manage a person's estate after death.

**Permanently unconscious state** means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

**Principal** means a competent adult who signs a Health Care Power of Attorney.

**Terminal condition** means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal's attending physician and one other physician who has examined the principal, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

**Ward** means the person the court has determined to be incompetent. The ward's person, financial estate, or both, is protected by a guardian the court appoints and oversees.

**Naming of My Agent.** The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's name and relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_



**By placing my initials, signature, check or other mark in this box, I specifically authorize my agent to obtain my protected health care information immediately and at any future time.**

**Guidance to Agent.** My agent will make health care decisions for me based on my instructions in this document and my wishes otherwise known to my agent. If my agent believes that my wishes conflict with what is in this document, this document will take precedence. If there are no instructions and if my wishes are unclear or unknown for any particular situation, my agent will determine my best interests after considering the benefits, the burdens and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

**Naming of alternate agent(s).** If my agent named above is not immediately available or is unwilling or unable to make decisions for me, then I name, in the following order of priority, the persons listed below as my alternate agents (*cross out any unused lines*):

X out area if not used	First alternate agent's name and relationship: _____
	Address: _____
	Telephone number(s): _____
	Second alternate agent's name and relationship: _____
	Address: _____
	Telephone number(s): _____

Any person can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

**Authority of Agent.** Except for those items I have crossed out and subject to any choices I have made in this Health Care Power of Attorney, my agent has full and complete authority to make all health care decisions for me. This authority includes, but is not limited to, the following:

1. To consent to the administration of pain-relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death.
2. If I am in a terminal condition and I do not have a Living Will Declaration that addresses treatment for such condition, to make decisions regarding life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.
3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, interventions or other measure.
4. To request, review and receive any information, verbal or written, regarding my physical or mental condition, including, but not limited to, all my medical and health care records.
5. To consent to further disclosure of information and to disclose medical and related information concerning my condition and treatment to other persons.
6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.
7. To execute consents, waivers and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any person who acts while relying on this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.
8. To select, employ and discharge health care personnel and services providing home health care and the like.
9. To select, contract for my admission to, transfer me to or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.
10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, if I am in a place where the terms of this document are not enforced.
11. To complete and sign for me the following:
  - Consents to health care treatment, or to the issuing of Do Not Resuscitate (DNR) Orders or other similar orders; and
  - Requests to be transferred to another facility, to be discharged against health care advice, or other similar requests; and
  - Any other document desirable or necessary to implement health care decisions that my agent is authorized to make pursuant to this document.

**Special Instructions.**



By placing my initials, signature, check or other mark in this box, I specifically authorize my agent to refuse or, if treatment has started, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration if I am in a permanently unconscious state AND my physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain.

[R.C. §1337.13(E)(2)(a) and (b)]

**Limitations of Agent’s Authority.** I understand there are limitations to the authority of my agent under Ohio law:

1. My agent does not have authority to refuse or withdraw informed consent to health care necessary to provide comfort care.
2. My agent does not have the authority to refuse or withdraw informed consent to health care if I am pregnant, if the refusal or withdrawal of the health care would terminate the pregnancy, unless the pregnancy or the health care would pose a substantial risk to my life, or unless my attending physician and at least one other physician to a reasonable degree of medical certainty determines that the fetus would not be born alive.
3. My agent cannot order the withdrawal of life-sustaining treatment, including artificially or technologically supplied nutrition or hydration, unless I am in a terminal condition or in a permanently unconscious state and two physicians have determined that life-sustaining treatment would not or would no longer provide comfort to me or alleviate my pain.
4. If I previously consented to any health care, my agent cannot withdraw that treatment unless my condition has significantly changed so that the health care is significantly less beneficial to me, or unless the health care is not achieving the purpose for which I chose the health care.

**Additional Instructions or Limitations.** I may give additional instructions or impose additional limitations on the authority of my agent. Below are my specific instructions or limitations:

If the space below is not sufficient, you may attach additional pages. If you do not have any additional instructions or limitations, write “None” below.

**NOMINATION OF GUARDIAN**

[R.C. §1337.28 (A) and R.C. §2111.121]

I understand that any person I nominate is not required to accept the duties of guardianship, and that the probate court maintains jurisdiction over any guardianship. [R.C. §2111.121(C)]

I understand that the court will honor my nominations except for good cause shown or disqualification. [R.C. §2111.121(B)]

I understand that, if a guardian is appointed for me, this or any subsequent Health Care Power of Attorney will continue unless the court limits, suspends or terminates this or any subsequent Health Care Power of Attorney upon a finding that the limitation, suspension or termination is in my best interests. [R.C. §1337.28 (C)]

I understand that the court also has the power to require a bond if the court finds it to be necessary.

**I intend that the authority given to my agent in my Health Care Power of Attorney will eliminate the need for any court to appoint a guardian of my person.** However, should such proceedings start, I nominate the person(s) below in the order listed as **guardian of my person**.

By writing my initials, signature, a check mark or other mark in this box, I nominate my agent and alternate agent(s), if any, to be **guardian of my person**, in the order named above.

If I do not choose my agent or an alternate agent to be the **guardian of my person**, I choose the following person(s), in this order (*cross out any unused lines*):

X out area if not used

Guardian of my person's name and relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

Alternate guardian of my person's name and relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

By placing my initials, signature, check or other mark in this box, I nominate my agent or alternate agent(s), if any, as **guardian of my estate**, in the order named above.

If I do not choose my agent or an alternate agent to be the **guardian of my estate**, I choose the following person(s), in this order (*cross out any unused lines*):

X out area if not used

Guardian of my estate and relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

Alternate guardian of my estate and relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

By placing my initials, signature, check or other mark in this box, I direct that bond be waived for guardian or successor **guardian of my estate**. [R.C. §1337.28 (B)]

If I do **not** make any mark in this box, it means that I expect the guardian or successor guardian of my estate to be bonded. [R.C. §1337.28 (B)]

**No Expiration Date.** This Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time.

**Enforcement by Agent.** My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document.

**Release of Agent's Personal Liability.** My agent will not be liable to me or any other person for any breach of duty unless such breach of duty was committed dishonestly, with an improper motive, or with reckless indifference to the purposes of this document or my best interests. [R.C. §1337.35]

**Copies are the Same as Original.** Any person may rely on a copy of this document. [R.C. §1337.26(D)]

**Out of State Application.** I intend that this document be honored in any jurisdiction to the extent allowed by law. [R.C. §1337.26(C)]

I have completed a **Living Will**:

Yes \_\_\_\_\_ No \_\_\_\_\_

**SIGNATURE of PRINCIPAL**

I understand that I am responsible for telling members of my family and my physician, my lawyer, my religious advisor and others about this Health Care Power of Attorney. I understand I may give copies of this Health Care Power of Attorney to any person.

I understand that I may file a copy of this Health Care Power of Attorney with the probate court for safekeeping. [R.C. §1337.12(E)(3)]

I understand that I must sign this Health Care Power of Attorney and state the date of my signing, and that my signing either must be witnessed by two adults who are eligible to witness my signing OR the signing must be acknowledged before a notary public. [R.C. §1337.12]

I sign my name to this Health Care Power of Attorney

on \_\_\_\_\_, 20\_\_\_\_, at \_\_\_\_\_, Ohio.

\_\_\_\_\_  
Principal

**[Choose Witnesses OR a Notary Acknowledgment.]**

**WITNESSES [R.C. §1337.12(B)]**

*[The following persons CANNOT serve as a witness to this Health Care Power of Attorney:*

- *Your agent, if any;*
- *The guardian of your person or estate, if any;*
- *Any alternate or successor agent or guardian, if any;*
- *Anyone related to you by blood, marriage, or adoption (for example, your spouse and children);*
- *Your attending physician; and*
- *The administrator of any nursing home where you are receiving care.]*



***I attest that the Principal signed or acknowledged this Health Care Power of Attorney in my presence, and that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.***

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Witness One's Signature                      Witness One's Printed Name                      Date

\_\_\_\_\_  
Witness One's Address

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Witness Two's Signature                      Witness Two's Printed Name                      Date

\_\_\_\_\_  
Witness Two's Address

**OR, if there are no witnesses:**

**NOTARY ACKNOWLEDGMENT [R.C. §1337.12]**

State of Ohio

County of \_\_\_\_\_ ss.

On \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned notary public, personally appeared \_\_\_\_\_, principal of the above Health Care Power of Attorney, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

My Commission is Permanent: \_\_\_\_\_

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### NOTICE TO ADULT EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact NEVER will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment, unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

(a) You are suffering from an irreversible, incurable and untreatable condition caused by disease, illness, or injury from which

(i) there can be no recovery and

(ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself;

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). **(You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other**

Notice as required by Ohio Revised Code §1337.17

medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently, if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then, subject to (4) below, your attorney in fact would be authorized to refuse or withdraw informed consent to the procedure, treatment, intervention, or other measure.);

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

**(4) Refuse or withdraw informed consent to the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, unless:**

**(a) You are in a terminal condition or in a permanently unconscious state.**

**(b) Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.**

**(c) If, but only if, you are in a permanently unconscious state, you authorize the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document:**

**(i) Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;**

**(ii) Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.**

**(d) Your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the above requirements of (4)(c)(i) and (ii) above.**

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

**Notice as required by Ohio Revised Code §1337.17**

Generally, you may designate any competent adult as the attorney in fact under this document. However, you CANNOT designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicates it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or when you acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses. If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

#### **Notice as required by Ohio Revised Code §1337.17**

#### **ADDENDUM**

This notice was not updated when certain provisions of the law regarding the Health Care Power of Attorney were changed in March 2014. Please be advised of the following changes:

You may, but are not required to, authorize your agent to get your health information, including information that is protected by law and otherwise not available to your agent. You can authorize your agent to have access to your health information immediately upon your signing of this document or at any later time, even though you are still able to make your own health care decisions.

You may also, but are not required to, use this document to name guardians for you or your estate should guardianship proceedings be started.

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