HEALTHCARE PROXY

FOR _____ **Social Security Number** _____

I, _____, Date of Birth _____, being of sound mind

voluntarily designate and appoint_____

Whose address is _____

and phone number (_____) _____ as my agent, or attorney-in-fact, to make decisions regarding my health care during periods when my health care provider has determined that I lack capacity to decide for myself. Specifically, and not to limit any other rights prescribed by Arkansas Statutes, my attorney-in-fact shall have the power: to have access to my medical records for treatment or payment decisions; to disclose medical records for purposes of treatment, payment, or health care operation; to employ and discharge physicians; to consent to or refuse to medical procedures, including the withholding or withdrawal of life-sustaining treatment, and nutrition and hydration, according to my wishes expressed in my Living Will. If I have no Living Will, or if my wishes are unclear under the existing circumstances of my medical condition, then upon consideration of my best interests as determined by my physician in consultation with my agent; my agent can admit me to hospitals, including psychiatric hospitals, nursing homes, or hospice care; and sign all appropriate forms, consents and releases in connection with any said matters.

If _____resigns, or is not able or available to make health care decision for me, or if an agent named by me is divorced from me or is my spouse and legally separated from me,

I appoint _____

whose address is _____

and phone number (_____) _____ as successor, with all of the rights and powers and authority herein stated.

Signed this _____day of _____, 20_____

_____
Signature

We, the undersigned, do hereby certify that the Declarant,_____ subscribed this Declaration of HealthCare Proxy in our presence, and we, at his or her request, in his or her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint, having a full understanding of what was being signed, and that his/her signature was voluntary.

Signed this _____day of _____, 20 _____.

_____	_____
Witness Signature	Witness Signature
_____	_____
Address	Address
_____	_____
Address	Address

JEFFERSON REGIONAL MEDICAL CENTER
HEALTHCARE PROXY

ADMIT PHY.