HB2373

LRB09804014HEP34034b

98TH GENERAL ASSEMBLY

State of Illinois

2013 and 2014

HB2373

by Rep. Ann Williams

SYNOPSIS AS INTRODUCED:

755 ILCS 45/4-4	from Ch. 110 1/2, par. 804-4
755 ILCS 45/4-5.1	
755 ILCS 45/4-10	from Ch. 110 1/2, par. 804-10

Amends the Illinois Power of Attorney Act. Replaces the statutory short form power of attorney for health care and the notice to the individual signing the power of attorney for health care. Defines "health care agent" and deletes the definitions of "incurable or irreversible condition", "permanent unconsciousness", and "terminal condition". Provides that no witness to the signing of a health care agency may be under 18 years of age. Provides that nonstatutory health care powers must meet certain criteria.

LRB098 04014 HEP 34034 b

A BILL FOR

AN ACT concerning civil law.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Power of Attorney Act is amended by changing Sections 4-4, 4-5.1, and 4-10 as follows:

(755 ILCS 45/4-4) (from Ch. 110 1/2, par. 804-4)

Sec. 4-4. Definitions. As used in this Article:

(a) "Attending physician" means the physician who has primary responsibility at the time of reference for the treatment and care of the patient.

(b) "Health care" means any care, treatment, service or procedure to maintain, diagnose, treat or provide for the patient's physical or mental health or personal care.

(c) "Health care agency" means an agency governing any type of health care, anatomical gift, autopsy or disposition of remains for and on behalf of a patient and refers to the power of attorney or other written instrument defining the agency or the agency, itself, as appropriate to the context.

(d) "Health care provider" or "provider" means the attending physician and any other person administering health care to the patient at the time of reference who is licensed, certified, or otherwise authorized or permitted by law to administer health care in the ordinary course of business or

the practice of a profession, including any person employed by or acting for any such authorized person.

(e) "Patient" means the principal or, if the agency governs health care for a minor child of the principal, then the child.

(e-5) "Health care agent" means an individual at least 18 years old designated by a person to make health care decisions of any type, including, but not limited to, anatomical gift, autopsy, or disposition of remains for and on behalf of the individual. A health care agent is a personal representative under State and federal law, but may not be the principal's physician or health care provider.

(f) (Blank). ~~"Incurable or irreversible condition" means an illness or injury (i) for which there is no reasonable prospect of cure or recovery, (ii) that ultimately will cause the patient's death even if life-sustaining treatment is initiated or continued, (iii) that imposes severe pain or otherwise imposes an inhumane burden on the patient, or (iv) for which initiating or continuing life sustaining treatment, in light of the patient's medical condition, provides only minimal medical benefit.~~

(g) (Blank). ~~"Permanent unconsciousness" means a condition that, to a high degree of medical certainty, (i) will last permanently, without improvement, (ii) in which thought, sensation, purposeful action, social interaction, and awareness of self and environment are absent, and (iii) for which initiating or continuing life sustaining treatment, in~~

~~light of the patient's medical condition, provides only minimal medical benefit. For the purposes of this definition, "medical benefit" means a chance to cure or reverse a condition.~~

(h) (Blank). ~~"Terminal condition" means an illness or injury for which there is no reasonable prospect of cure or recovery, death is imminent, and the application of life sustaining treatment would only prolong the dying process.~~

(Source: P.A. 96-1195, eff. 7-1-11.)

(755 ILCS 45/4-5.1)

Sec. 4-5.1. Limitations on who may witness health care agencies.

(a) Every health care agency shall bear the signature of a witness to the signing of the agency. No witness may be under 18 years of age. None of the following may serve as a witness to the signing of a health care agency:

(1) the attending physician or mental health service provider of the principal, or a relative of the physician or provider;

(2) an owner, operator, or relative of an owner or operator of a health care facility in which the principal is a patient or resident;

(3) a parent, sibling, or descendant, or the spouse of a parent, sibling, or descendant, of either the principal or any agent or successor agent, regardless of whether the

relationship is by blood, marriage, or adoption;

(4) an agent or successor agent for health care.

(b) The prohibition on the operator of a health care facility from serving as a witness shall extend to directors and executive officers of an operator that is a corporate entity but not other employees of the operator such as, but not limited to, non-owner chaplains or social workers.

(Source: P.A. 96-1195, eff. 7-1-11.)

(755 ILCS 45/4-10) (from Ch. 110 1/2, par. 804-10)

Sec. 4-10. Statutory short form power of attorney for health care.

(a) The form prescribed in this Section (sometimes also referred to in this Act as the "statutory health care power") may be used to grant an agent powers with respect to the principal's own health care; but the statutory health care power is not intended to be exclusive nor to cover delegation of a parent's power to control the health care of a minor child, and no provision of this Article shall be construed to invalidate or bar use by the principal of any other or different form of power of attorney for health care. Nonstatutory health care powers must at a minimum contain the following ~~be executed by the principal, designate the agent and the agent's powers, and comply with Section 4-5 of this Article~~, but they need not be witnessed or conform in any other respect to the statutory health care power:

(1) the principal's name and address;

(2) language nominating an agent who is at least 18 years of age;

(3) the agent's name and address;

(4) an effective date or effective condition, such as when a physician determines that the principal can no longer make decisions;

(5) language specifying the agent's authority to make decisions for the principal;

(6) specific limitations to the agent's power, if any; and

(7) the principal's signature and date.

~~When a power of attorney in substantially the form prescribed in this Section is used, including the "Notice to the Individual Signing the Illinois Statutory Short Form Power of Attorney for Health Care" (or "Notice" paragraphs) at the beginning of the form on a separate sheet in 14 point type, it shall have the meaning and effect prescribed in this Act. A power of attorney for health care shall be deemed to be in substantially the same format as the statutory form if the explanatory language throughout the form (the language following the designation "NOTE:") is distinguished in some way from the legal paragraphs in the form, such as the use of boldface or other difference in typeface and font or point size, even if the "Notice" paragraphs at the beginning are not on a separate sheet of paper or are not in 14 point type, or if~~

~~the principal's initials do not appear in the acknowledgement at the end of the "Notice" paragraphs.~~ The statutory health care power may be included in or combined with any other form of power of attorney governing property or other matters.

(b) The Illinois Statutory Short Form Power of Attorney for Health Care shall be substantially as follows:

NOTICE TO THE INDIVIDUAL SIGNING

THE POWER OF ATTORNEY FOR HEALTH CARE

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your "health care agent". Your agent is the person you trust to make health care decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an "advance directive". You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and on-line resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing

your advance directive.

WHAT ARE THE THINGS I WANT MY HEALTH CARE AGENT TO KNOW?

The selection of your agent should be considered carefully, as your agent will have the ultimate decision making authority once this document goes into effect, in most instances after you are no longer able to voice your own decisions. While the goal is for your agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your agent to make decisions in real time to direct or refuse health care interventions or withdraw treatment which in rare circumstances may override your stated preferences. Your agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

(i) What is most important to you in your life?

(ii) How important is it to you to avoid pain and suffering?

(iii) If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?

(iv) Would you rather be at home or in a hospital for the last days or weeks of your life?

(v) Do you have religious, spiritual, or cultural beliefs that you want your agent and others to consider?

(vi) Do you have an existing advanced directive, such as a living will, that contains your specific wishes about health care that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.

WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

If there is ever a period of time when your doctor determines that you cannot make your own health care decisions, or if you do not want to make your own decisions, some of the decisions your agent could make are to:

(i) Talk with doctors and other health care providers about your condition.

(ii) See medical records and approve who else can see them.

(iii) Give permission for medical tests, medicines, surgery, or other treatments.

(iv) Choose where you receive care and which doctors and others provide it.

(v) Decide to accept, withdraw, or decline treatments designed to keep you alive if you are near death or not

likely to recover. You may choose to include guidelines and/or restrictions to your agent's authority.

(vi) Agree or decline to donate your organs if you have not already made this decision yourself. This could include donation for transplant, research, and/or education. You should let your agent know whether you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State.

(vii) Decide what to do with your remains after you have died, if you have not already made plans.

(viii) Talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones).

Your agent is not automatically responsible for your health care expenses.

WHOM SHOULD I CHOOSE TO BE MY HEALTH CARE AGENT?

You can pick a family member, but you do not have to. Your agent will have the responsibility to make medical treatment decisions together with your doctor and other professionals, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend, or other person who:

(i) is at least 18 years old;

(ii) knows you well;

(iii) you trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;

(iv) would be comfortable talking with and questioning your doctors and other health care providers;

(v) would not be too upset to carry out your wishes if you became very sick; and

(vi) can be there for you when you need it and is willing to accept this important role.

WHAT IF MY AGENT IS NOT AVAILABLE OR IS UNWILLING TO MAKE DECISIONS FOR ME?

If the person who is your first choice is unable to carry out this role when the time comes, you can choose one or more successor agents. Your successor agents function as back-up agents to your first choice agent and may act only one at a time and in the order you list them.

WHAT WILL HAPPEN IF I DO NOT CHOOSE A HEALTH CARE AGENT?

If you become unable to make your own health care decisions and have not named an agent in writing, your doctor and other health care providers will ask a family member, friend, or guardian to make decisions for you. In Illinois, a law directs

which of these individuals will be consulted. In that law, each of these individuals is called a "surrogate".

There are reasons why you may want to name an agent rather than rely on a surrogate:

(i) The person or people listed by this law may not be who you would want to make decisions for you.

(ii) Some family members or friends might not be able or willing to make decisions as you would want them to.

(iii) Family members and friends may disagree with one another about the best decisions.

(iv) Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

WHAT IF THERE IS NO ONE AVAILABLE

WHOM I TRUST TO BE MY AGENT?

In this situation, it is especially important to talk to your doctor and other health care providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes. You can complete a living will. You can also write your wishes down and/or discuss them with your doctor or other health care provider and ask him or her to write it down in your chart. You might also want to use written or on-line resources to guide you through this process.

WHAT DO I DO WITH THIS FORM ONCE I COMPLETE IT?

Follow these instructions after you have completed the form:

(i) Sign the form in front of a witness. See the form for a list of who can and cannot witness it.

(ii) Ask the witness to sign it, too.

(iii) There is no need to have the form notarized.

(iv) Give a copy to your agent and to each of your successor agents.

(v) Give another copy to your doctor.

(vi) Take a copy with you when you go to the hospital.

(vii) Show it to your family and friends and others who care for you.

WHAT IF I CHANGE MY MIND?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one.

WHAT IF I DO NOT WANT TO USE THIS FORM?

In the event you do not want to use the Illinois statutory form provided here, any document you complete must comply with the following minimum requirements to qualify as a valid power of attorney for health care:

(i) it must list your name and address;

(ii) it must contain language nominating your agent;

(iii) it must list your agent's name and address;

(iv) it must contain an effective date or effective condition such as when a physician determines that you can no longer make decisions for yourself;

(v) it must describe your agent's authority to make decisions for you;

(vi) it must list specific limitations to your agent's power, if any; and

(vii) it must contain your signature and date.

If you have questions about the use of any form, you may want to consult your doctor, other health care provider, and/or an attorney. While Illinois law does not require the use of an attorney to complete a power of attorney, individuals may consult an attorney to address any questions or to seek assistance in completing the document.

MY POWER OF ATTORNEY FOR HEALTH CARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTH CARE. (You must sign this form and a witness must also sign it before it is valid)

My name (Print your full name): .....

My address: .....

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT

(an agent is your personal representative under state and federal law, but your agent may not be your physician or health care provider):

(Agent name) .....

(Agent address) .....

(Agent phone number) .....

MY AGENT CAN MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING:

(i) Deciding to accept, withdraw or decline treatment for any physical or mental condition of mine, including life-and-death decisions.

(ii) Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.

(iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

(iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue or body donation, autopsy, cremation, and burial.

I AUTHORIZE MY AGENT TO (please check any one box):

.... Make decisions for me only when I cannot make them for

myself. The physician(s) taking care of me will determine when I lack this ability.

.... Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

SELECT THE STATEMENT OR STATEMENTS BELOW THAT BEST EXPRESS YOUR WISHES (optional):

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. Some general statements concerning the withholding or removal of life-sustaining treatment are described below. This can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements.

.... If my agent thinks the burdens of the treatments will probably be greater than any benefits, I do not want treatments to prolong my life. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment. Treatments I would not want if I were to reach this point include but are not limited to tube feedings or fluids through a tube, breathing machines, and CPR.

.... In the event that I am unconscious and my attending physician believes that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life.

.... I want my life to be prolonged to the greatest extent possible, in accordance with reasonable medical standards, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are.

.... I prefer not to select any of the above statements.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:

.....

.....

My signature: .....

Today's date: .....

HAVE YOUR WITNESS AGREE TO WHAT IS WRITTEN BELOW, AND THEN COMPLETE THE SIGNATURE PORTION:

I am at least 18 years old. I saw the principal sign this document of ..... (fill in number) pages, or the principal told me that the signature or mark on the principal signature line is his or hers. I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent,

or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, mental health service provider, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness printed name: .....

Witness address: .....

Witness signature: .....

Today's date: .....

SUCCESSOR HEALTH CARE AGENT(S) (optional):

If the agent I selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names):

.....

(Successor agent #1 name, address and phone number)

.....

(Successor agent #2 name, address and phone number)

SAMPLE SIGNATURES OF AGENT AND SUCCESSOR AGENT(S) (optional):

You may, but are not required to, request your agent and successor agents to provide sample signatures below. If you include sample signatures in this power of attorney, you must

complete the certification opposite the signatures of the agents.

I certify that the following signatures of my agent and successor agents are correct:

..... (agent) ..... (principal)

..... (agent) ..... (principal)

..... (agent) ..... (principal)

~~"NOTICE TO THE INDIVIDUAL SIGNING THE ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE~~

~~PLEASE READ THIS NOTICE CAREFULLY. The form that you will be signing is a legal document. It is governed by the Illinois Power of Attorney Act. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.~~

~~The purpose of this Power of Attorney is to give your designated "agent" broad powers to make health care decisions for you, including the power to require, consent to, or withdraw treatment for any physical or mental condition, and to admit you or discharge you from any hospital, home, or other institution. You may name successor agents under this form, but you may not name co-agents.~~

~~This form does not impose a duty upon your agent to make such health care decisions, so it is important that you select~~

~~an agent who will agree to do this for you and who will make those decisions as you would wish. It is also important to select an agent whom you trust, since you are giving that agent control over your medical decision-making, including end of life decisions. Any agent who does act for you has a duty to act in good faith for your benefit and to use due care, competence, and diligence. He or she must also act in accordance with the law and with the statements in this form. Your agent must keep a record of all significant actions taken as your agent.~~

~~Unless you specifically limit the period of time that this Power of Attorney will be in effect, your agent may exercise the powers given to him or her throughout your lifetime, even after you become disabled. A court, however, can take away the powers of your agent if it finds that the agent is not acting properly. You may also revoke this Power of Attorney if you wish.~~

~~The Powers you give your agent, your right to revoke those powers, and the penalties for violating the law are explained more fully in Sections 4-5, 4-6, and 4-10(c) of the Illinois Power of Attorney Act. This form is a part of that law. The "NOTE" paragraphs throughout this form are instructions.~~

~~You are not required to sign this Power of Attorney, but it will not take effect without your signature. You should not sign it if you do not understand everything in it, and what your agent will be able to do if you do sign it.~~

~~Please put your initials on the following line indicating that you have read this Notice:~~

~~.....~~

~~(Principal's initials)"~~

~~"ILLINOIS STATUTORY SHORT FORM~~

~~POWER OF ATTORNEY FOR HEALTH CARE~~

~~1. I, ..., (insert name and address of principal) hereby revoke all prior powers of attorney for health care executed by me and appoint: ..... (insert name and address of agent) (NOTE: You may not name co-agents using this form.) as my attorney in fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue.~~

~~A. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others.~~

~~B. Effective upon my death, my agent has the full power to make an anatomical gift of the following:~~

~~(NOTE: Initial one. In the event none of the options are initialed, then it shall be concluded that you do not wish to grant your agent any such authority.)~~

~~.... Any organs, tissues, or eyes suitable for transplantation or used for research or education.~~

~~.... Specific organs: .....~~

~~.... I do not grant my agent authority to make any anatomical gifts.~~

~~C. My agent shall also have full power to authorize an autopsy and direct the disposition of my remains. I intend for this power of attorney to be in substantial compliance with Section 10 of the Disposition of Remains Act. All decisions made by my agent with respect to the disposition of my remains, including cremation, shall be binding. I hereby direct any cemetery organization, business operating a crematory or columbarium or both, funeral director or embalmer, or funeral establishment who receives a copy of this document to act under it.~~

~~D. I intend for the person named as 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, including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations~~

~~thereunder. I intend for the person named as my agent to serve as my "personal representative" as that term is defined under HIPAA and regulations thereunder.~~

~~(i) The person named as my agent shall have the power to authorize the release of information governed by HIPAA to third parties.~~

~~(ii) I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Informational Bureau, Inc., or any other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment for me for such services to give, disclose, and release to the person named as 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, drug or alcohol abuse, and mental illness (including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act).~~

~~(iii) The authority given to the person named as my agent shall supersede any prior agreement that I may have with my health care providers to restrict access to, or disclosure of, my individually identifiable health information. The authority given to the person named as 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.~~

~~(NOTE: The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care, including withdrawal of food and water and other life sustaining measures, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to make an anatomical gift, authorize autopsy or dispose of remains, you may do so in the following paragraphs.)~~

~~2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations:~~

~~(NOTE: Here you may include any specific limitations you deem appropriate, such as: your own definition of when life sustaining measures should be withheld; a direction to continue food and fluids or life sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.)~~

~~.....~~

.....

.....

.....

.....

(NOTE: The subject of life sustaining treatment is of particular importance. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life sustaining treatment are set forth below. If you agree with one of these statements, you may initial that statement; but do not initial more than one. These statements serve as guidance for your agent, who shall give careful consideration to the statement you initial when engaging in health care decision-making on your behalf.)

I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

Initialed .....

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued, unless I am, in the opinion of my attending physician, in accordance with reasonable medical standards at the time of reference, in a state of "permanent unconsciousness" or suffer from an

"incurable or irreversible condition" or "terminal condition", as those terms are defined in Section 4-4 of the Illinois Power of Attorney Act. If and when I am in any one of these states or conditions, I want life-sustaining treatment to be withheld or discontinued.

Initialed .....

I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards without regard to my condition, the chances I have for recovery or the cost of the procedures.

Initialed .....

(NOTE: This power of attorney may be amended or revoked by you in the manner provided in Section 4-6 of the Illinois Power of Attorney Act.)

3. This power of attorney shall become effective on .....

.....

(NOTE: Insert a future date or event during your lifetime, such as a court determination of your disability or a written determination by your physician that you are incapacitated, when you want this power to first take effect.)

(NOTE: If you do not amend or revoke this power, or if you do not specify a specific ending date in paragraph 4, it will remain in effect until your death; except that your agent will still have the authority to donate your organs, authorize an autopsy, and dispose of your remains after your death, if you

~~grant that authority to your agent.)~~

~~4. This power of attorney shall terminate on.....~~

~~.....~~

~~(NOTE: Insert a future date or event, such as a court determination that you are not under a legal disability or a written determination by your physician that you are not incapacitated, if you want this power to terminate prior to your death.)~~

~~(NOTE: You cannot use this form to name co-agents. If you wish to name successor agents, insert the names and addresses of the successors in paragraph 5.)~~

~~5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent:~~

~~.....~~

~~.....~~

~~For purposes of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor, or an adjudicated incompetent or disabled person, or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.~~

~~(NOTE: If you wish to, you may name your agent as guardian of your person if a court decides that one should be appointed. To do this, retain paragraph 6, and the court will appoint your agent if the court finds that this appointment will serve your~~

~~best interests and welfare. Strike out paragraph 6 if you do not want your agent to act as guardian.)~~

~~6. If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.~~

~~7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.~~

~~Dated: .....~~

~~Signed .....~~

~~(principal's signature or mark)~~

~~The principal has had an opportunity to review the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence. The undersigned witness certifies that the witness is not: (a) the attending physician or mental health service provider or a relative of the physician or provider; (b) an owner, operator, or relative of an owner or operator of a health care facility in which the principal is a patient or resident; (c) a parent, sibling, descendant, or any spouse of such parent, sibling, or descendant of either the principal or any agent or successor agent under the foregoing power of attorney, whether such relationship is by blood, marriage, or adoption; or (d) an agent or successor agent under the foregoing power of attorney.~~

~~.....~~

~~(Witness Signature)~~

~~.....~~

~~(Print Witness Name)~~

~~.....~~

~~(Street Address)~~

~~.....~~

~~(City, State, ZIP)~~

~~(NOTE: You may, but are not required to, request your agent and successor agents to provide specimen signatures below. If you include specimen signatures in this power of attorney, you must complete the certification opposite the signatures of the agents.)~~

~~Specimen signatures of agent (and successors).~~

~~I certify that the signatures of my agent (and successors) are correct.~~

~~.....~~

~~(agent)~~

~~.....~~

~~(successor agent)~~

~~.....~~

~~(successor agent)~~

~~.....~~

~~(principal)~~

~~.....~~

~~(principal)~~

~~.....~~

~~(principal)"~~

~~(NOTE: The name, address, and phone number of the person preparing this form or who assisted the principal in completing this form is optional.)~~

~~.....~~

~~(name of preparer)~~

.....

.....

(address)

.....

(phone)

(c) The statutory short form power of attorney for health care (the "statutory health care power") authorizes the agent to make any and all health care decisions on behalf of the principal which the principal could make if present and under no disability, subject to any limitations on the granted powers that appear on the face of the form, to be exercised in such manner as the agent deems consistent with the intent and desires of the principal. The agent will be under no duty to exercise granted powers or to assume control of or responsibility for the principal's health care; but when granted powers are exercised, the agent will be required to use due care to act for the benefit of the principal in accordance with the terms of the statutory health care power and will be liable for negligent exercise. The agent may act in person or through others reasonably employed by the agent for that purpose but may not delegate authority to make health care decisions. The agent may sign and deliver all instruments, negotiate and enter into all agreements and do all other acts reasonably necessary to implement the exercise of the powers granted to the agent. Without limiting the generality of the foregoing, the statutory health care power shall include the

~~following powers, subject to any limitations appearing on the face of the form:~~

~~(1) The agent is authorized to give consent to and authorize or refuse, or to withhold or withdraw consent to, any and all types of medical care, treatment or procedures relating to the physical or mental health of the principal, including any medication program, surgical procedures, life sustaining treatment or provision of food and fluids for the principal.~~

~~(2) The agent is authorized to admit the principal to or discharge the principal from any and all types of hospitals, institutions, homes, residential or nursing facilities, treatment centers and other health care institutions providing personal care or treatment for any type of physical or mental condition. The agent shall have the same right to visit the principal in the hospital or other institution as is granted to a spouse or adult child of the principal, any rule of the institution to the contrary notwithstanding.~~

~~(3) The agent is authorized to contract for any and all types of health care services and facilities in the name of and on behalf of the principal and to bind the principal to pay for all such services and facilities, and to have and exercise those powers over the principal's property as are authorized under the statutory property power, to the extent the agent deems necessary to pay health care costs;~~

~~and the agent shall not be personally liable for any services or care contracted for on behalf of the principal.~~

~~(4) At the principal's expense and subject to reasonable rules of the health care provider to prevent disruption of the principal's health care, the agent shall have the same right the principal has to examine and copy and consent to disclosure of all the principal's medical records that the agent deems relevant to the exercise of the agent's powers, whether the records relate to mental health or any other medical condition and whether they are in the possession of or maintained by any physician, psychiatrist, psychologist, therapist, hospital, nursing home or other health care provider.~~

~~(5) The agent is authorized: to direct that an autopsy be made pursuant to Section 2 of "An Act in relation to autopsy of dead bodies", approved August 13, 1965, including all amendments; to make a disposition of any part or all of the principal's body pursuant to the Illinois Anatomical Gift Act, as now or hereafter amended; and to direct the disposition of the principal's remains.~~

(Source: P.A. 96-1195, eff. 7-1-11; 97-148, eff. 7-14-11.)