

1 AN ACT concerning civil law.

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

4 Section 5. The Illinois Power of Attorney Act is amended by  
5 changing Sections 4-4, 4-5, 4-5.1, 4-10, and 4-12 as follows:

6 (755 ILCS 45/4-4) (from Ch. 110 1/2, par. 804-4)

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

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

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

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

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

1 course of business or the practice of a profession, including  
2 any person employed by or acting for any such authorized  
3 person.

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

6 (e-5) "Health care agent" means an individual at least 18  
7 years old designated by a person to make health care decisions  
8 of any type, including, but not limited to, anatomical gift,  
9 autopsy, or disposition of remains for and on behalf of the  
10 individual. A health care agent is a personal representative  
11 under state and federal law, but may not be the principal's  
12 physician or health care provider. The health care agent has  
13 the authority of a personal representative under both state and  
14 federal law unless restricted specifically by the health care  
15 agency.

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

25 (g) (Blank). ~~"Permanent unconsciousness" means a condition~~  
26 ~~that, to a high degree of medical certainty, (i) will last~~

1 ~~permanently, without improvement, (ii) in which thought,~~  
2 ~~sensation, purposeful action, social interaction, and~~  
3 ~~awareness of self and environment are absent, and (iii) for~~  
4 ~~which initiating or continuing life-sustaining treatment, in~~  
5 ~~light of the patient's medical condition, provides only minimal~~  
6 ~~medical benefit. For the purposes of this definition, "medical~~  
7 ~~benefit" means a chance to cure or reverse a condition.~~

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

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

14 (755 ILCS 45/4-5) (from Ch. 110 1/2, par. 804-5)

15 Sec. 4-5. Limitations on health care agencies. Neither the  
16 attending physician nor any other health care provider or  
17 health care professional may act as agent under a health care  
18 agency; however, a person who is not administering health care  
19 to the patient may act as health care agent for the patient  
20 even though the person is a physician or otherwise licensed,  
21 certified, authorized, or permitted by law to administer health  
22 care in the ordinary course of business or the practice of a  
23 profession.

24 (Source: P.A. 86-736.)

1 (755 ILCS 45/4-5.1)

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

4 (a) Every health care agency shall bear the signature of a  
5 witness to the signing of the agency. No witness may be under  
6 18 years of age. None of the following licensed professionals  
7 providing services to the principal may serve as a witness to  
8 the signing of a health care agency:

9 (1) the attending physician, advanced practice nurse,  
10 physician assistant, dentist, podiatric physician,  
11 optometrist, or mental health service provider of the  
12 principal, or a relative of the physician, advanced  
13 practice nurse, physician assistant, dentist, podiatric  
14 physician, optometrist, or mental health service provider;

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

18 (3) a parent, sibling, or descendant, or the spouse of  
19 a parent, sibling, or descendant, of either the principal  
20 or any agent or successor agent, regardless of whether the  
21 relationship is by blood, marriage, or adoption;

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

23 (b) The prohibition on the operator of a health care  
24 facility from serving as a witness shall extend to directors  
25 and executive officers of an operator that is a corporate  
26 entity but not other employees of the operator such as, but not

1 limited to, non-owner chaplains or social workers, nurses, and  
2 other employees.

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

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

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

7 (a) The form prescribed in this Section (sometimes also  
8 referred to in this Act as the "statutory health care power")  
9 may be used to grant an agent powers with respect to the  
10 principal's own health care; but the statutory health care  
11 power is not intended to be exclusive nor to cover delegation  
12 of a parent's power to control the health care of a minor  
13 child, and no provision of this Article shall be construed to  
14 invalidate or bar use by the principal of any other or  
15 different form of power of attorney for health care.  
16 Nonstatutory health care powers must be executed by the  
17 principal, designate the agent and the agent's powers, and  
18 comply with the limitations in Section 4-5 of this Article, but  
19 they need not be witnessed or conform in any other respect to  
20 the statutory health care power.

21 ~~When a power of attorney in substantially the form~~  
22 ~~prescribed in this Section is used, including the "Notice to~~  
23 ~~the Individual Signing the Illinois Statutory Short Form Power~~  
24 ~~of Attorney for Health Care" (or "Notice" paragraphs) at the~~  
25 ~~beginning of the form on a separate sheet in 14 point type, it~~

1 ~~shall have the meaning and effect prescribed in this Act. A~~  
2 ~~power of attorney for health care shall be deemed to be in~~  
3 ~~substantially the same format as the statutory form if the~~  
4 ~~explanatory language throughout the form (the language~~  
5 ~~following the designation "NOTE:") is distinguished in some way~~  
6 ~~from the legal paragraphs in the form, such as the use of~~  
7 ~~boldface or other difference in typeface and font or point~~  
8 ~~size, even if the "Notice" paragraphs at the beginning are not~~  
9 ~~on a separate sheet of paper or are not in 14 point type, or if~~  
10 ~~the principal's initials do not appear in the acknowledgement~~  
11 ~~at the end of the "Notice" paragraphs.~~ The statutory health  
12 care power may be included in or combined with any other form  
13 of power of attorney governing property or other matters.

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

16 NOTICE TO THE INDIVIDUAL SIGNING

17 THE POWER OF ATTORNEY FOR HEALTH CARE

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

23 In Illinois, you can choose someone to be your "health care  
24 agent". Your agent is the person you trust to make health care  
25 decisions for you if you are unable or do not want to make them

1 yourself. These decisions should be based on your personal  
2 values and wishes.

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

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

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

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

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

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

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

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

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

19 WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

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

24 (i) talk with physicians and other health care  
25 providers about your condition.



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

3           (iii) give permission for medical tests, medicines,  
4           surgery, or other treatments.

5           (iv) choose where you receive care and which physicians  
6           and others provide it.

7           (v) decide to accept, withdraw, or decline treatments  
8           designed to keep you alive if you are near death or not  
9           likely to recover. You may choose to include guidelines  
10           and/or restrictions to your agent's authority.

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

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

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

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

24           WHOM SHOULD I CHOOSE TO BE MY HEALTH CARE AGENT?

25           You can pick a family member, but you do not have to. Your

1 agent will have the responsibility to make medical treatment  
2 decisions together with your physician and other  
3 professionals, even if other people close to you might urge a  
4 different decision. The selection of your agent should be done  
5 carefully, as he or she will have ultimate decision-making  
6 authority for your treatment decisions once you are no longer  
7 able to voice your preferences. Choose a family member, friend,  
8 or other person who:

9 (i) is at least 18 years old;

10 (ii) knows you well;

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

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

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

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

20 WHAT IF MY AGENT IS NOT AVAILABLE OR IS

21 UNWILLING TO MAKE DECISIONS FOR ME?

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

1 time and in the order you list them.

2 WHAT WILL HAPPEN IF I DO NOT

3 CHOOSE A HEALTH CARE AGENT?

4 If you become unable to make your own health care decisions  
5 and have not named an agent in writing, your physician and  
6 other health care providers will ask a family member, friend,  
7 or guardian to make decisions for you. In Illinois, a law  
8 directs which of these individuals will be consulted. In that  
9 law, each of these individuals is called a "surrogate".

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

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

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

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

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

21 WHAT IF THERE IS NO ONE AVAILABLE

22 WHOM I TRUST TO BE MY AGENT?

23 In this situation, it is especially important to talk to  
24 your physician and other health care providers and create

1 written guidance about what you want or do not want, in case  
2 you are ever critically ill and cannot express your own wishes.  
3 You can complete a living will. You can also write your wishes  
4 down and/or discuss them with your physician or other health  
5 care provider and ask him or her to write it down in your  
6 chart. You might also want to use written or on-line resources  
7 to guide you through this process.

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

9 Follow these instructions after you have completed the  
10 form:

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

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

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

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

17 (v) Give another copy to your physician.

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

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

21 WHAT IF I CHANGE MY MIND?

22 You may change your mind at any time. If you do, tell  
23 someone who is at least 18 years old that you have changed your  
24 mind, and/or destroy your document and any copies. If you wish,

1 fill out a new form and make sure everyone you gave the old  
2 form to has a copy of the new one.

3 WHAT IF I DO NOT WANT TO USE THIS FORM?

4 In the event you do not want to use the Illinois statutory  
5 form provided here, any document you complete must be executed  
6 by you, designate an agent authorized by law to serve as an  
7 agent, and state the agent's powers, but it need not be  
8 witnessed or conform in any other respect to the statutory  
9 health care power.

10 If you have questions about the use of any form, you may  
11 want to consult your physician, other health care provider,  
12 and/or an attorney.

13 MY POWER OF ATTORNEY FOR HEALTH CARE

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

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

18 My address: .....

19 I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT

20 (an agent is your personal representative under state and  
21 federal law, but your physician or health care provider cannot

1 be designated as your agent):

2 (Agent name) .....

3 (Agent address) .....

4 (Agent phone number) .....

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

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

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

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

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

19 The above grant of power is intended to be as broad as  
20 possible so that your agent will have the authority to make any  
21 decision you could make to obtain or terminate any type of  
22 health care, including withdrawal of nutrition and hydration  
23 and other life-sustaining measures.

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

1       .... Make decisions for me only when I cannot make them for  
2       myself. The physician(s) taking care of me will determine  
3       when I lack this ability.

4       (If no box is checked, then the box above shall be  
5       implemented.) OR

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

10       The subject of life-sustaining treatment is of particular  
11       importance. Life-sustaining treatments may include tube  
12       feedings or fluids through a tube, breathing machines, and CPR.  
13       In general, in making decisions concerning life-sustaining  
14       treatment, your agent is instructed to consider the relief of  
15       suffering, the quality as well as the possible extension of  
16       your life, and your previously expressed wishes. Your agent  
17       will weigh the burdens versus benefits of proposed treatments  
18       in making decisions on your behalf.

19       Additional statements concerning the withholding or  
20       removal of life-sustaining treatment are described below.  
21       These can serve as a guide for your agent when making decisions  
22       for you. Ask your physician or health care provider if you have  
23       any questions about these statements.

24       SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES

1 (optional):

2 .... The quality of my life is more important than the  
3 length of my life. If I am unconscious and my attending  
4 physician believes, in accordance with reasonable medical  
5 standards, that I will not wake up or recover my ability to  
6 think, communicate with my family and friends, and  
7 experience my surroundings, I do not want treatments to  
8 prolong my life.

9 .... Staying alive is more important to me, no matter how  
10 sick I am, how much I am suffering, the cost of the  
11 procedures, or how unlikely my chances for recovery are. I  
12 want my life to be prolonged to the greatest extent  
13 possible in accordance with reasonable medical standards.

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

15 The above grant of power is intended to be as broad as  
16 possible so that your agent will have the authority to make any  
17 decision you could make to obtain or terminate any type of  
18 health care. If you wish to limit the scope of your agent's  
19 powers or prescribe special rules or limit the power to  
20 authorize autopsy or dispose of remains, you may do so  
21 specifically in this form.

22 .....  
23 .....

24 My signature: .....



1 Today's date: .....

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

4 I am at least 18 years old. (check one of the options  
5 below):

6 .... I saw the principal sign this document, or  
7 .... the principal told me that the signature or mark on  
8 the principal signature line is his or hers.

9 I am not the agent or successor agent(s) named in this  
10 document. I am not related to the principal, the agent, or the  
11 successor agent(s) by blood, marriage, or adoption. I am not  
12 the principal's physician, mental health service provider, or a  
13 relative of one of those individuals. I am not an owner or  
14 operator (or the relative of an owner or operator) of the  
15 health care facility where the principal is a patient or  
16 resident.

17 Witness printed name: .....

18 Witness address: .....

19 Witness signature: .....

20 Today's date: .....

21 SUCCESSOR HEALTH CARE AGENT(S) (optional):

22 If the agent I selected is unable or does not want to make  
23 health care decisions for me, then I request the person(s) I  
24 name below to be my successor health care agent(s). Only one

1 person at a time can serve as my agent (add another page if you  
2 want to add more successor agent names):

3 .....

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

5 .....

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

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

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

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

21 ~~This form does not impose a duty upon your agent to make~~  
22 ~~such health care decisions, so it is important that you select~~  
23 ~~an agent who will agree to do this for you and who will make~~  
24 ~~those decisions as you would wish. It is also important to~~

1 ~~select an agent whom you trust, since you are giving that agent~~  
2 ~~control over your medical decision-making, including~~  
3 ~~end-of-life decisions. Any agent who does act for you has a~~  
4 ~~duty to act in good faith for your benefit and to use due care,~~  
5 ~~competence, and diligence. He or she must also act in~~  
6 ~~accordance with the law and with the statements in this form.~~  
7 ~~Your agent must keep a record of all significant actions taken~~  
8 ~~as your agent.~~

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

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

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

25 ~~Please put your initials on the following line indicating~~

1 ~~that you have read this Notice.~~

2 .....  
3 ~~(Principal's initials)"~~

4 ~~"ILLINOIS STATUTORY SHORT FORM~~  
5 ~~POWER OF ATTORNEY FOR HEALTH CARE~~

6 1. I, .....,  
7 ~~(insert name and address of principal) hereby revoke all prior~~  
8 ~~powers of attorney for health care executed by me and appoint:~~  
9 .....  
10 ~~(insert name and address of agent)~~

11 ~~(NOTE: You may not name co-agents using this form.)~~

12 ~~as my attorney in fact (my "agent") to act for me and in my~~  
13 ~~name (in any way I could act in person) to make any and all~~  
14 ~~decisions for me concerning my personal care, medical~~  
15 ~~treatment, hospitalization and health care and to require,~~  
16 ~~withhold or withdraw any type of medical treatment or~~  
17 ~~procedure, even though my death may ensue.~~

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

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

23 ~~(NOTE: Initial one. In the event none of the options are~~  
24 ~~initialed, then it shall be concluded that you do not wish to~~

1 ~~grant your agent any such authority.)~~

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

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

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

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

17 ~~D. I intend for the person named as my agent to be treated~~  
18 ~~as I would be with respect to my rights regarding the use and~~  
19 ~~disclosure of my individually identifiable health information~~  
20 ~~or other medical records, including records or communications~~  
21 ~~governed by the Mental Health and Developmental Disabilities~~  
22 ~~Confidentiality Act. This release authority applies to any~~  
23 ~~information governed by the Health Insurance Portability and~~  
24 ~~Accountability Act of 1996 ("HIPAA") and regulations~~  
25 ~~thereunder. I intend for the person named as my agent to serve~~  
26 ~~as my "personal representative" as that term is defined under~~

1 ~~HIPAA and regulations thereunder.~~

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

5 ~~(ii) I authorize any physician, health care professional,~~  
6 ~~dentist, health plan, hospital, clinic, laboratory, pharmacy~~  
7 ~~or other covered health care provider, any insurance company~~  
8 ~~and the Medical Informational Bureau, Inc., or any other health~~  
9 ~~care clearinghouse that has provided treatment or services to~~  
10 ~~me, or that has paid for or is seeking payment for me for such~~  
11 ~~services to give, disclose, and release to the person named as~~  
12 ~~my agent, without restriction, all of my individually~~  
13 ~~identifiable health information and medical records, regarding~~  
14 ~~any past, present, or future medical or mental health~~  
15 ~~condition, including all information relating to the diagnosis~~  
16 ~~and treatment of HIV/AIDS, sexually transmitted diseases, drug~~  
17 ~~or alcohol abuse, and mental illness (including records or~~  
18 ~~communications governed by the Mental Health and Developmental~~  
19 ~~Disabilities Confidentiality Act).~~

20 ~~(iii) The authority given to the person named as my agent~~  
21 ~~shall supersede any prior agreement that I may have with my~~  
22 ~~health care providers to restrict access to, or disclosure of,~~  
23 ~~my individually identifiable health information. The authority~~  
24 ~~given to the person named as my agent has no expiration date~~  
25 ~~and shall expire only in the event that I revoke the authority~~  
26 ~~in writing and deliver it to my health care provider.~~

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

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

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

24 .....  
 25 .....  
 26 .....

1 .....  
.....

2 .....  
.....

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

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

19 ~~Initialed .....~~

20 ~~I want my life to be prolonged and I want life sustaining~~  
21 ~~treatment to be provided or continued, unless I am, in the~~  
22 ~~opinion of my attending physician, in accordance with~~  
23 ~~reasonable medical standards at the time of reference, in a~~  
24 ~~state of "permanent unconsciousness" or suffer from an~~  
25 ~~"incurable or irreversible condition" or "terminal condition",~~  
26 ~~as those terms are defined in Section 4-4 of the Illinois Power~~





1 .....  
2

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

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

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

15 .....  
16 .....

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

22 ~~(NOTE: If you wish to, you may name your agent as guardian of~~  
23 ~~your person if a court decides that one should be appointed. To~~  
24 ~~do this, retain paragraph 6, and the court will appoint your~~  
25 ~~agent if the court finds that this appointment will serve your~~  
26 ~~best interests and welfare. Strike out paragraph 6 if you do~~  
~~not want your agent to act as guardian.)~~

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

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

7 Dated: .....

8 Signed .....

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

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

23 .....

24 ~~(Witness Signature)~~

25 .....

1 ~~(Print Witness Name)~~

2 ~~.....~~

3 ~~(Street Address)~~

4 ~~.....~~

5 ~~(City, State, ZIP)~~

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

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

13 ~~.....~~ ~~.....~~

14 ~~(agent)~~ ~~(principal)~~

15 ~~.....~~ ~~.....~~

16 ~~(successor agent)~~ ~~(principal)~~

17 ~~.....~~ ~~.....~~

18 ~~(successor agent)~~ ~~(principal)"~~

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

22 ~~.....~~

23 ~~(name of preparer)~~

24 ~~.....~~

25 ~~.....~~

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

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

18           ~~(3) The agent is authorized to contract for any and all~~  
19           ~~types of health care services and facilities in the name of~~  
20           ~~and on behalf of the principal and to bind the principal to~~  
21           ~~pay for all such services and facilities, and to have and~~  
22           ~~exercise those powers over the principal's property as are~~  
23           ~~authorized under the statutory property power, to the~~  
24           ~~extent the agent deems necessary to pay health care costs;~~  
25           ~~and the agent shall not be personally liable for any~~  
26           ~~services or care contracted for on behalf of the principal.~~

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

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

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

20           (755 ILCS 45/4-12) (from Ch. 110 1/2, par. 804-12)

21           Sec. 4-12. Saving clause. This Act does not in any way  
22           invalidate any health care agency executed or any act of any  
23           agent done, or affect any claim, right or remedy that accrued,  
24           prior to September 22, 1987.

25           This amendatory Act of the 96th General Assembly does not

1 in any way invalidate any health care agency executed or any  
2 act of any agent done, or affect any claim, right, or remedy  
3 that accrued, prior to the effective date of this amendatory  
4 Act of the 96th General Assembly.

5 This amendatory Act of the 98th General Assembly does not  
6 in any way invalidate any health care agency executed or any  
7 act of any agent done, or affect any claim, right, or remedy  
8 that accrued, prior to the effective date of this amendatory  
9 Act of the 98th General Assembly.

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

11 Section 99. Effective date. This Act takes effect January  
12 1, 2015.