

COLORADO MEDICAL DURABLE POWER OF ATTORNEY

I, _____, hereby appoint

Name of Agent

as my agent to make health care decisions for me.

Home Phone

Mobile Phone

Address

City / State / Zip Code

If the person named as my agent is not available or is unable or unwilling to act as my agent, I then appoint the person listed below to serve:

Name of Alternate Agent

Home Phone

Mobile Phone

Address

City / State / Zip Code

Patient signature required on reverse side.

MDPOA

Health Care Agent

the conversation project
in boulder county

a program of **T R U** | COMMUNITYCARE

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This gives my agent the power to consent to giving, withholding or stopping any health care, treatment, service or diagnostic procedure. My agent also has the authority to talk with health care personnel about my condition, access my medical records, get information and sign forms necessary to carry out those decisions, and make hospitalization and institutional placement decisions.

By this document I intend to create a Medical Durable Power of Attorney, to take effect upon my incapacity to make my own health care decisions and to continue during my incapacity. My agent shall make health care decisions as I have directed or made known to him/her. If I have not expressed a choice about the health care in question, my agent shall base the decision on what he/she believes is in my best interest.

By signing here I indicate that I understand the purpose and effect of this document.

Patient Signature

Date

Pursuant to Colorado Revised Statute 15-14-701 – 745

Birth Date

Allergies

Serious Medical Conditions

Primary Care Physician

Physician Phone