ADVANCED HEALTH CARE DIRECTIVE

Health Care Power of Attorney for _____
(print name)

You have the right to give instructions and make decisions about your own health care. You also have the right to name someone else to make health care decisions for you. If you use this form, you may complete or change all or any part of it. You are free to use a different form. You have the right to change this Advance Health Care Directive or replace this form at any time.

1. **DESIGNATION OF AGENT**. I name the following as my agent to make health care decisions for me:

   Name of Agent: _____

   Agent's Address: _____

   Agent's Phone Number: _____

   Optional: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my alternate agent:

   Alternative: _____

   Agent's Address: _____

   Agent's Phone Number: _____

2. **AGENT'S AUTHORITY**: My agent is authorized to make all health-care decisions for me, including end-of-life decisions.
3. **HIPAA Authorization**: My agent(s) named above shall have the status, power, authority and rights as my Personal Representative(s) for all purposes as provided in the Health Insurance Portability and Accountability Act of 1996, (Pub. L. 104-191), 45 CFR Section 160 through 164 (HIPAA). All provisions under this Section shall be effective immediately for all purposes and shall continue to be effective until three years after my death.
4. **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE**. My agent's authority to make health-care decisions for me is effective immediately.

5. **AGENT'S OBLIGATION**: My agent shall make health-care decisions for me in accordance with my wishes to the extent known to them. If my wishes are unknown, then my agent must make decisions in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known.
6. **NOMINATION OF GUARDIAN**: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form.
7. **EFFECT OF COPY**: A copy of this form has the same effect as the original.
8. **SIGNATURES**: Sign and date the form here:

_____

(date) (sign your name)

NOTARY ACKNOWLEDGEMENT

STATE OF MISSISSIPPI
COUNTY OF _____

On this _____ day of _____, in the year _____, before me, _____ (insert name of notary public) appeared _____ (insert name of person signing), personally known to me (or proved to me based on satisfactory evidence) to be the person whose name is subscribed to this document and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

_____
NOTARY PUBLIC

My Commission Expires:

_____