

**INDIANA POWER OF ATTORNEY FOR HEALTH CARE DECISIONS  
AND APPOINTMENT OF HEALTH CARE REPRESENTATIVE  
PAGE 1 OF 3**

**INSTRUCTIONS**

**PRINT YOUR NAME  
AND ADDRESS**

1) I, \_\_\_\_\_  
(name)

of \_\_\_\_\_  
(address)

hereby appoint \_\_\_\_\_  
(name of attorney-in-fact)

**PRINT THE NAME,  
ADDRESS AND  
TELEPHONE  
NUMBERS OF  
YOUR ATTORNEY-  
IN-FACT**

\_\_\_\_\_  
(address)

(home telephone number) \_\_\_\_\_ (work telephone number)

as my attorney-in-fact to make health care decisions on my behalf  
whenever I am incapable of making my own health care decisions.

I grant my attorney-in-fact the following powers in matters affecting my  
health care:

**POWERS OF YOUR  
ATTORNEY-IN-FACT**

1. to employ or contract with servants, companions, or health care providers involved in my health care;
2. to admit or release me from a hospital or health care facility;
3. to have access to my records, including medical records; concerning my condition;
4. to make anatomical gifts on my behalf;
5. to request an autopsy; and
6. to make plans for the disposition of my body.

**INDIANA POWER OF ATTORNEY FOR HEALTH CARE  
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PRINT THE NAME,  
ADDRESS AND  
TELEPHONE  
NUMBERS OF  
YOUR ALTERNATE  
ATTORNEY-IN-FACT

2) In the event the person I appoint above is unable, unwilling or unavailable to act as my attorney-in-fact, I hereby appoint:

\_\_\_\_\_ (name of successor attorney-in-fact)

of \_\_\_\_\_

\_\_\_\_\_ (address)

\_\_\_\_\_ (home telephone number)

\_\_\_\_\_ (work telephone number)

as my successor attorney-in-fact.

APPOINTMENT AND  
POWERS OF HEALTH  
CARE  
REPRESENTATIVE

**Appointment of my Attorney-in-Fact as my Health Care Representative;  
Decisions Regarding Withdrawing or Withholding Health Care**

In addition to the powers granted above, I appoint my attorney-in-fact as my **health care representative**, and authorize my attorney-in-fact and health care representative to make decisions in my best interest concerning the consent, withdrawal or withholding of health care. I understand health care to include any medical care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental well-being. Health care also includes the providing of nutrition and hydration through intravenous, endotracheal or nasogastric tubes.

If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent they are available.

**INDIANA POWER OF ATTORNEY FOR HEALTH CARE  
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PRINT YOUR NAME  
AND THE DATE

I, \_\_\_\_\_, the principal, sign my name to  
this instrument this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_,  
(date) (month) (year)

and do hereby declare to the undersigned witness that I sign it willingly, and I  
execute it as my free and voluntary act for the purposes herein expressed, and  
that I am eighteen years of age or older, of sound mind, and under no constraint  
or undue influence.

SIGN THE DOCUMENT

\_\_\_\_\_  
(principal)

Subscribed and acknowledged before me by \_\_\_\_\_,  
the principal, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

A NOTARY PUBLIC  
MUST COMPLETE  
THIS SECTION OF  
YOUR DOCUMENT

\_\_\_\_\_  
(notary public)

My Commission expires \_\_\_\_\_

**Courtesy of Caring Connections**

1731 King St., Suite 100,

Alexandria, VA 22314

[www.caringinfo.org](http://www.caringinfo.org)

800-658-8898