INDIANA HEALTH CARE PROXY

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HEALTH POWERS OF ATTORNEY FORM FOR INDIANA RESIDENTS

I, _____

_____(Insert your name and address as principal)

appoint _____

_____(Insert name and address of the person appointed) as my agent (attorney-in-fact) to act for me in any lawful way with respect to the Health Care Powers that may include acting as my agent with respect to mental health and addictions treatment services, as defined and described in the Annotated Indiana Code, which is incorporated by reference herein:

Health care powers. (Indiana Code § 30-5-5-16)

Sec. 16. (a) This section does not prohibit an individual capable of consenting to the individual's own health care or to the health care of another from consenting to health care administered in good faith under the religious tenets and practices of the individual requiring health care.

(b) Language conferring general authority with respect to health care powers means the principal authorizes the attorney in fact to do the following:

(1) Employ or contract with servants, companions, or health care providers to care for the principal.

(2) If the attorney in fact is an individual, consent to or refuse health care for the principal who is an individual in accordance with IC 16-36-4 and IC 16-36-1 by properly executing and attaching to the power of attorney a declaration or appointment, or both.

(3) Admit or release the principal from a hospital or health care facility.

(4) Have access to records, including medical records, concerning the principal's condition.

(5) Make anatomical gifts on the principal's behalf.

(6) Request an autopsy.

(7) Make plans for the disposition of the principal's body.

If you wish your agent to be able to withdraw or withhold health care or to be able to access and discuss treatment information specific to mental health and/or alcohol or drug treatment as described below, check the respective boxes below:

☐ I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care (pursuant to Ann. Ind. Code §§ 30-5-5-17, 16-31-1, and 16-36-4). 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.

☐ I authorize my health care representative to access/receive specially protected treatment information and to discuss such information with health care providers to coordinate my care for the initialed areas below.

☐ Mental Health Records (IC 16-39-2-9) ☐ Drug and Alcohol Records (CFR 42 Part II)

☐ HIV/AIDS Records (IC 16-41-8) ☐ Infectious Disease Records (IC 16-41-8)

My heath care representative must try to discuss care decisions 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.

CHECK ONE OF THE FOLLOWING BOXES:

☐ This power of attorney shall terminate upon my disability, incapacity or incompetence.

☐ This power of attorney is effective immediately, and shall not be affected by my disability, incapacity or incompetence.

☐ This power of attorney will become effective upon my disability, incapacity or incompetence.

I understand that in accordance with Indiana Code 30-5-10-1, except as otherwise stated in this power of attorney form, this executed power of attorney may be revoked only in writing wherein the written revocation statement identifies the power of attorney revoked and is signed by myself, the principal. This power of attorney shall continue in full force and effect until I have executed and recorded in the Recorder's Office of the county of my domicile a written revocation hereof.

Signed this _____ day of _____, _____.

_____ _____

(Your signature) (Your social security number)

State of _____. County of _____.

On this _____day of _____, _____, before me personally appeared _____ (name of principal), who is personally known to me or provided _____as identification, and acknowledged that he or she executed this health powers of attorney form.

_____

Notary Public

CRITICAL STEP:
SHARE YOUR COMPLETED DOCUMENT!

Your document is only helpful if people know where to find it when it is needed. It's important to discuss the decisions outlined in your document with anyone you designate to act on your behalf in a health emergency. Here's a quick guide to sharing your document once it has been completed and satisfies the legal requirements for your state (if applicable).

WHO NEEDS A COPY OF YOUR DOCUMENT?

- Anyone assigned a decision-making role in the document
- A spouse or significant other
- A trusted family member or friend
- Any doctors you see on a regular basis
- Any hospital or facility in which you regularly receive care
- A lawyer and/or estate planner, if you have one

HOW TO SHARE YOUR DOCUMENT

1) **Use Cake!** Upload your document to a free Cake account for safekeeping. Share 24/7 secure document access with anyone that has an email address*

   Create your free Cake account: www.joincake.com/share-free

2) **Or, print** and provide copies to everyone who needs one

WHY PLAN & SHARE WITH CAKE?

- Get a personalized checklist that guides you through each step
- Make healthcare, financial, funeral, and legacy decisions
- Create, upload, and print all your end-of-life documents
- Share 24/7 document access with anyone that has an email address*

Create your free Cake account: www.joincake.com/share-free

** Some healthcare providers may require a paper copy of your document to be able to enter it into their records.*