



Nebraska Power of Attorney for Health Care

I, _____, the Principal, appoint _____, whose address is _____, and whose telephone number is _____, as my **Attorney-in-Fact** for Health Care.

If the above named Attorney-in-Fact for Health Care is either unable or unwilling to act as my Attorney-in-Fact for Health Care, I hereby appoint _____, whose address is _____, and whose telephone number is _____, as my **Successor Attorney-in-Fact** for Health Care.

I direct that my Attorney-in-Fact comply with the following instructions or limitations with regard to my Health Care wishes (this may include my wishes for, but are not limited to, instructions on life-sustaining treatment and artificially administered nutrition and hydration): _____

I authorize my Attorney in-Fact to make health care decisions for me, including life and death decisions, when it is determined by my treating physician or physicians, that I lack capacity to make my own health care decisions. I understand that I may request a second opinion to confirm my capacity. In addition, I authorize the release of medical records to my Attorney-in-Fact or Successor Attorney-in-Fact, as set forth above. I have discussed or will discuss my Health Care wishes with my Attorney-in-Fact or Successor Attorney-in-Fact. I also understand that I can revoke this Power of Attorney for Health Care at any time by notifying my Attorney-in-Fact, my treating physician(s), or the facility in which I am a patient or resident.

I HAVE READ THIS POWER OF ATTORNEY FOR HEALTH CARE AND I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE HEALTH CARE, LIFE AND DEATH DECISIONS FOR ME, IF IT IS DETERMINED THAT I AM UNABLE TO MAKE SUCH DECISIONS.

Signature _____ Address _____
Printed Name _____ Date _____

Declaration of Witnesses

THIS DOCUMENT **MUST BE** SIGNED BY TWO WITNESSES **OR** A NOTARY PUBLIC

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this Power of Attorney for Health Care in our presence, and that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us, nor the principal's attending Physician, Nurse Practitioner, or Physician's Assistant is the person appointed as attorney-in-fact.

Witness Signature _____ Witness Signature _____
Print Name _____ Print Name _____
Address _____ Address _____
Date _____ Date _____

OR

State of Nebraska)
County of _____)
On this _____ day of _____ 20____, before me, _____,
a notary public in and for _____ County, _____
voluntarily signed this document in my presence.
Witness my hand and notarial seal at _____ in such county the day and year last written.
Notary Signature _____ Seal

Patient Label
NAME: _____ DOB: _____
FIN: _____ MRN: _____