DECLARATION FOR MEDICAL CARE

To my family, clergyman, physician, attorney, any medical facility where I may be a patient, and any person who may be responsible for my health, welfare, or care. When I am unable to participate in my medical treatment decisions, this Declaration shall stand as an expression of my wishes and directions.

I have a right to make my own decisions concerning treatment that may unduly prolong the dying process. I wish to live and enjoy life as long as possible. However, I do not wish to receive medical treatment which will only postpone the moment of my death from an incurable and terminal condition, prolong an irreversible coma, or continue medical treatment under any circumstances where my condition is such that my physical or cognitive abilities are significantly and permanently impaired. For purposes of this Declaration: 1) "terminal condition" means a condition that is reasonably expected to result in my death in a relatively short time regardless of the treatment that I may receive; 2) "irreversible coma" shall mean a permanent loss of consciousness from which there is no reasonable possibility that I may return to a cognitive and discerning life, and shall include, but not be limited to, a persistent vegetative state; and 3) “significantly and permanently impaired physical or cognitive abilities” shall mean the inability to care for myself, dependency on others to perform the activities of daily living, the inability to interact with people or my surroundings, and substantial impairment of cognitive or sensory capacity.

Therefore, if I am unable to participate in my medical treatment decisions, and my condition is terminal as defined above or if I am in an irreversible coma as defined above or that

my physical or cognitive abilities are significantly and permanently impaired as defined above, then I direct that:

1. Treatment or procedures which will only postpone the moment of my death or prolong an irreversible coma not be instituted or, if previously instituted, that they be discontinued.

2. Procedures other than manual feeding used to provide me with nourishment and hydration not be instituted or, if previously instituted, that they be discontinued.

3. Treatment or procedures that are available to maintain or assist me, if my physical or cognitive abilities are significantly and permanently impaired not be instituted or, if previously instituted, that they be discontinued

4. My physician administer whatever is appropriate to keep me as comfortable and free of pain as is reasonably possible, including the administration of pain relieving drugs of any kind or other surgical or medical procedures calculated to relieve pain, even though such drugs or procedures may lead to permanent physical damage, addiction or hasten the moment of (but not actually cause) my death.

I acknowledge that if medical treatment or procedures are withheld or withdrawn that such a decision could or would allow my death. I desire that my wishes as expressed herein be carried out despite any contrary feelings, beliefs or opinions of my family, relatives, friends, conservator, or guardian.

In addition to the power listed above, my Patient Advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of me if I am unable to participate in my medical treatment decisions, including specifically, by way of illustration only and not by way of limitation:

1. Access to my medical and other personal information. To request, review, and receive any information, verbal or written, regarding my personal affairs or my physical or mental health, including medical and hospital records, and to execute any releases or other documents that may be required in order to obtain this information.

2. Employ and discharge others. To direct my Agent under my Durable Power of Attorney of even date herewith to employ and discharge physicians, psychiatrists, dentists, nurses and therapists, domestic help, and other professionals as my Patient Advocate may deem necessary for my physical, mental and emotional well being, and to have my said Agent pay them or any of them reasonable compensation.

3. Consent, or withhold consent, to my medical care. To give consent or withhold consent on my behalf with respect to:

a. Any medical care, diagnosis, surgical procedure, therapeutic procedure and/or other treatment of any type or nature;

b. Any physical rehabilitation program;

c. Any dental procedure;

d. Any psychiatric or psychological care or treatment;

e. The admission to any hospital, medical center, convalescent care, nursing home, mental institution, hospice or home care;

f. The use of any drugs, medication therapeutic devices, or other medicines or items related to my health;

g. The protection of my right of privacy and the right to make decisions regarding medical treatment even though the exercise of my rights might hasten my death or be against conventional medical advice.

h. The execution of waivers, medical authorizations and such other approval as may be required to permit or authorize care which I may need, or to discontinue care that I am receiving;

i. The revocation, withdrawal, or modification of any medical care, surgery, or any other medical procedures or tests, hospitalization, convalescent care, hospice or home care which I, or my Patient Advocate, may have previously allowed or consented to, or to which may have been implied due to emergency conditions;

j. The waiver of any doctor-patient privilege and the power in general to take and authorize all acts with respect to my health and well being, and to direct my said agent to expend all amounts in connection therewith, to the same extent as I could. The prices, costs, expenses and compensation incurred in furtherance of the foregoing are all to be within the sole and absolute discretion of my Patient Advocate. My Patient Advocate shall be guided in making such decisions by what I have told my Patient Advocate about my personal preferences regarding such care. Based on those same preferences, my Patient Advocate may also summon paramedics or other emergency medical personnel and seek emergency treatment for me, or choose not to do so, as my Patient Advocate deems appropriate given my wishes and my medical status at the time of the decision. My Patient Advocate has authorization, when dealing with hospitals and physicians, to sign documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice" as well as any necessary waivers of or releases from liability required by the hospitals or physicians to implement my wishes regarding medical treatment or nontreatment.

My Patient Advocate, my family, the medical facility, and any doctors, nurses and other medical persons involved in my care shall not be liable for honoring my wishes expressed in this document or for implementing the decisions of my Patient Advocate.

This Declaration is meant to be an unlimited, full and complete authorization for the release of any and all protected medical information as defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164, as amended, and under the rules and regulations thereunder, and covers all protected information. It is understood that the Patient Advocate to whom this authorization is given has my permission to use and disseminate this information in my Patient Advocate's sole discretion.

1. I intend for my Patient Advocate to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by HIPAA.

2. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services

- to give, disclose and release to my Patient Advocate, without restriction,
- all my individually identifiable health information and medical records regarding my past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

3. The authority given my Patient Advocate shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information.

4. The authority given my Patient Advocate has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it my health care provider.

For the purpose of inducing all persons, organizations, corporations and entities (hereinafter referred to as "persons") including, but not limited to, any physicians, hospital, nursing home, insurer, or other party, to act in accordance with the instructions of my Patient Advocate as authorized in this Declaration, I hereby represent, warrant and agree that:

1. If this Declaration is amended or revoked for any reason, I, my estate, my heirs, successors and assigns will hold any person harmless from any loss suffered, or liability incurred, by such person acting in accordance with the instructions of my Patient Advocate acting under this Declaration prior to the receipt by such person of actual notice of any such revocation or amendment.

2. Any person may rely upon the representations of my Patient Advocate as to all matters relating to any power granted to my Patient Advocate, the fact that my Patient Advocate's powers are then in effect, the scope of my Patient Advocate's authority granted under this Declaration, and no person who acts in reliance upon the representations of my Patient Advocate or the authority granted to my Patient Advocate shall incur any liability to me, my estate, my heirs or assigns as a result of permitting my Patient Advocate to exercise any such authority.

3. I hereby authorize my Patient Advocate to seek on my behalf and at my expense:

a. a declaratory judgment from any Court of competent jurisdiction interpreting the validity of this Declaration or any of the acts authorized by this Declaration, but such declaratory judgment shall not be necessary in order for my Patient Advocate to perform any act authorized by this Declaration; or

b. a mandatory injunction requiring compliance with my Patient Advocate's instructions by any person, organization, corporation, or other entity obligated to comply with instructions given by me; or

c. actual punitive damages against any person, organization, corporation or other entity obligated to comply with instructions given by me who negligently or willfully fails or refuses to follow such instructions.

This Declaration shall not be affected by my disability or by the lapse of time. My Patient Advocate may exercise the authority granted by this Declaration only when I am unable to participate in my medical treatment decisions.

This Declaration shall be governed by the laws of the State of Michigan in all respects including its validity, construction, interpretation, and determination. I intend that this Declaration for Medical Care be honored in any jurisdiction where it may be presented and for any such jurisdiction to refer to Michigan law to interpret and determine the validity of this Declaration and any of the powers granted under this Declaration.

I revoke all prior durable powers of attorney for health care (and/or Declarations for Medical Care) that I may have executed and I retain the right to revoke or amend this Declaration and to substitute other Patient Advocates in place of the Patient Advocate named

herein. Amendments to this Declaration shall be made in writing by me personally and shall be attached to the original of this Declaration.

My Patient Advocate is authorized to make photocopies of this Declaration as frequently and in such quantity as my Patient Advocate shall deem appropriate. All photocopies shall have the same force and effect as any original.

I hereby designate _____, as my Patient Advocate to make care, custody and medical treatment decisions for me in the event of my disability under this Declaration. I have discussed my wishes concerning terminal care with my Patient Advocate and I trust his/her judgment on my behalf. In the event _____ is unable or unwilling to act as my Patient Advocate, I hereby designate _____ as my Patient Advocate.

I understand the meaning of this Declaration, and I am emotionally and mentally competent to make it.

Dated: _____,

_____
(signature)

_____
(address):

_____
(city, state, zip)

We sign below as witnesses. This Declaration was signed in our presence. We know the declarant and he/she appears to be of sound mind, and to be making this Declaration voluntarily, and under no duress, fraud or undue influence.

_____ of _____

_____ of _____

STATE OF MICHIGAN)
) ss.
COUNTY OF)

On this_____ day of _____, 20__, before me, a Notary Public, personally appeared _____, who executed the above Declaration, and acknowledged the same to be his/her free act and deed.

_____
Notary Public