

MEDICAL POWER OF ATTORNEY

I, _____, social security number ____-____-____, date of birth _____, being at least eighteen years of age, designate as **my agent**:

Agent's Name: _____
Address: _____
Home Telephone: _____
Work Telephone: _____

My agent shall be entitled to receive information from healthcare personnel and to make every decision that I could make regarding my medical treatment during any period that I am not competent to effectively make or communicate my informed consent to, or refusal of, such treatment.

If the person named above as **my agent** is unavailable or unable to act as **my agent**, then I appoint the following person(s) to serve in that capacity in the order listed below (Appointment of one or more **alternate agents** is desirable, but not required):

Alternate Agent One:
Name: _____
Address: _____
Home Telephone: _____
Work Telephone: _____

Alternate Agent Two:
Name: _____
Address: _____
Home Telephone: _____
Work Telephone: _____

This power of attorney shall take effect upon any and every event of my incompetence to effectively make or communicate my informed consent to, or refusal of, medical treatment and continue for the duration of each such event.

Dated the ____ day of _____, 20 ____.

Signature

The following are optional, but recommended:

Agent: _____
Signature

STATE OF COLORADO)
) ss
COUNTY OF _____)

Subscribed, sworn to and acknowledged before me by _____,
the ____ day of _____, 20 ____.

Witness my hand and official seal
My commission expires _____

Notary Public

NOTE: State laws vary and this form may not be accepted in states other than Colorado.