

ARIZONA HEALTH CARE POWER OF ATTORNEY

By completing this document, I _____ (*principal*) intend to create a health care power of attorney designating a health care agent to make health care decisions on my behalf if and when I am unable to make or communicate decisions regarding my own health care. My agent shall have the power to give or refuse consent to all medical, surgical, hospital and related health care and any placement decisions (including a decision to withhold or discontinue treatment, when such a decision may lead to my natural death).

I designate _____ to be my health care agent.

If _____ is unable or unwilling to serve in this capacity, I designate _____ to be my agent.

Date _____ Signature _____
principal

Witness or Notary (*cannot be the person appointed as agent*):

I _____ was present when _____ dated and signed this document and _____ appeared to be of sound mind and free from duress at the time of signing. I am not directly involved with the provision of health care to the principal. I am not related to the principal by blood, marriage, or adoption and I am not entitled to any part of the principal's estate by will or operation of law.

Date _____ Signature _____
witness / notary

THIS FORM IS DESIGNED IN COMPLIANCE WITH A.R.S. 36-3221

Instructions: The *principal* is the person choosing the agent.
If there is only one agent named, cross out the sentence referring to a second agent.
You may use EITHER a witness or a notary for this document.