NOTICE TO THE INDIVIDUAL SIGNING THE
ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE

(NOTICE: THE FORM THAT YOU WILL BE SIGNING IS A LEGAL DOCUMENT. IT IS GOVERNED BY THE ILLINOIS POWER OF ATTORNEY ACT. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE YOUR DESIGNATED "AGENT" BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO REQUIRE, CONSENT TO OR WITHDRAW TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION, AND TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME OR OTHER INSTITUTION. YOU MAY NAME SUCCESSOR AGENTS UNDER THIS FORM, BUT YOU MAY NOT NAME CO-AGENTS.

THIS FORM DOES NOT IMPOSE A DUTY UPON YOUR AGENT TO MAKE SUCH HEALTH CARE DECISIONS, SO IT IS IMPORTANT THAT YOU SELECT AN AGENT WHO WILL AGREE TO DO THIS FOR YOU AND WHO WILL MAKE THOSE DEICISIONS AS YOU WOULD WISH. IT IS ALSO IMPORTANT TO SELECT AN AGENT WHOM YOU TRUST, SINCE YOU ARE GIVING THAT AGENT CONTROL OVER YOUR MEDICAL DECISION-MAKING, INCLUDING END-OF-LIFE DECISIONS. ANY AGENT WHO DOES ACT FOR YOU HAS A DUTY TO ACT IN GOOD FAITH FOR YOUR BENEFIT AND TO USE DUE CARE, COMPETENCE, AND DILIGENCE. HE OR SHE MUST ALSO ACT IN ACCORDANCE WITH THE LAW AND WITH THE STATEMENTS IN THIS FORM. YOUR AGENT MUST KEEP A RECORD OF ALL SIGNIFICANT ACTIONS TAKEN AS YOUR AGENT.

UNLESS YOU SPECIFICALLY LIMIT THE PERIOD OF TIME THAT THIS POWER OF ATTORNEY WILL BE IN EFFECT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN HERE THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED. A COURT, HOWEVER, CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THAT THE AGENT IS NOT ACTING PROPERLY. YOU MAY ALSO REVOKE THIS POWER OF ATTORNEY IF YOU WISH.

THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN SECTIONS 4-5, 4-6, 4-9 AND 4-10(b) OF THE ILLINOIS POWER OF ATTORNEY ACT. THIS FORM IS A PART OF THAT LAW. THE "NOTE" PARAGRAPHS THROUGHOUT THIS FORM ARE INSTRUCTIONS.

YOU ARE NOT REQUIRED TO SIGN THIS POWER OF ATTORNEY, BUT IT WILL NOT TAKE EFFECT WITHOUT YOUR SIGNATURE. YOU SHOULD NOT SIGN IT IF YOU DO NOT UNDERSTAND EVERYTHING IN IT, AND WHAT YOUR AGENT WILL BE ABLE TO DO IF YOU DO SIGN IT.

PLEASE PUT YOUR INITIALS ON THE FOLLOWING LINE INDICATING THAT YOU HAVE READ THIS NOTICE:

Initialed.....

ILLINOIS STATUTORY SHORT FORM
POWER OF ATTORNEY FOR HEALTH CARE

1. I, **[NAME] of Chicago, Illinois,** hereby revoke all prior powers of attorney for health care executed by me and appoint:

[NAME/ADDRESS]

as my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue.

A. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others.

B. Effective upon my death, my agent has the full power to make an anatomical gift of the following:

(NOTE: INITIAL ONE. IN THE EVENT NONE OF THE OPTIONS ARE INITIALED, THEN IT SHALL BE CONCLUDED THAT YOU DO NOT WISH TO GRANT YOUR AGENT ANY SUCH AUTHORITY.)

_____ Any organs, tissues, or eyes suitable for transplantation or used for research or education.

_____ Specific organs:_____

_____ I do not grant my agent authority to make any anatomical gifts.

C. My agent shall also have full power to authorize an autopsy and direct the disposition of my remains. I intend for this power of attorney to be in substantial compliance with Section 10 of the Disposition of Remains Act. All decisions made by my agent with respect to the disposition of my remains, including cremation, shall be binding. I hereby direct any cemetery organization, business operating a crematory or columbarium or both, funeral director or embalmer, or funeral establishment who receives a copy of this document to act under it.

D. I intend for the person named as my agent 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, including records of communications governed by the Mental Health and Developmental Disabilities Confidentiality Act. This release authority applies to any information governed by the Health

Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder. I intend for the person named as my agent to serve as my "personal representative" as that term is defined under HIPAA and regulations thereunder.

(i) The person named as my agent shall have the power to authorize the release of information governed by HIPAA to third parties. (ii) 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 any other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment for me for such services to give, disclose, and release to the person named as my agent, without restriction, all of my individually identifiable health information and medical records, regarding any part, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug or alcohol abuse, and mental illness (including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act). (iii) The authority given to the person named as my agent shall supersede any prior agreement that I may have with my health care providers to restrict access to, or disclosure of, my individually identifiable health information. The authority given to the person named as my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider. The authority given to the person named as my agent to serve as my "personal representative" as defined under HIPAA and regulations thereunder and to access my individually identifiable health information or authorize the release of the same to third parties shall take effect immediately, even if I designate in Paragraph 3 of this document that this agency shall otherwise take effect at some future date.

(NOTE: THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF FOOD AND WATER AND OTHER LIFE-SUSTAINING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES OR LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.)

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations:

(NOTE: HERE YOU MAY INCLUDE ANY SPECIFIC LIMITATIONS YOU DEEM APPROPRIATE, SUCH AS: YOUR OWN DEFINITION OF WHEN LIFE-SUSTAINING MEASURES SHOULD BE WITHHELD; A DIRECTION TO CONTINUE FOOD AND FLUIDS

OR LIFE-SUSTAINING TREATMENT IN ALL EVENTS; OR INSTRUCTIONS TO REFUSE ANY SPECIFIC TYPES OF TREATMENT THAT ARE INCONSISTENT WITH YOUR RELIGIOUS BELIEFS OR UNACCEPTABLE TO YOU FOR ANY OTHER REASON, SUCH AS BLOOD TRANSFUSION, ELECTRO-CONVULSIVE THERAPY, AMPUTATION, PSYCHOSURGERY, VOLUNTARY ADMISSION TO A MENTAL INSTITUTION, ETC.):

_____

_____

_____

(THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT; BUT DO NOT INITIAL MORE THAN ONE. THESE STATEMENTS SERVE AS GUIDANCE FOR YOUR AGENT, WHO SHALL GIVE CAREFUL CONSIDERATION TO THE STATEMENT YOU INITIAL WHEN ENGAGING IN HEALTH CARE DECISION-MAKING ON YOUR BEHALF.):

I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

Initialed _____

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am, in the opinion of my attending physician, in accordance with reasonable medical standards at the time of reference, in a state of “permanent unconsciousness” or suffer from an “incurable or irreversible condition” or “terminal condition,” as those terms are defined in Section 4-4 of the Illinois Power of Attorney Act. If and when I am in any one of these states or conditions, I want life-sustaining treatment to be withheld or discontinued.

Initialed_____

I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards without regard to my condition, the chances I have for recovery or the cost of the procedures.

Initialed.....

(NOTE: THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU IN THE MANNER PROVIDED IN SECTION 4-6 OF THE ILLINOIS POWER OF ATTORNEY ACT.

YOUR AGENT CAN ACT IMMEDIATELY, UNLESS YOU SPECIFY OTHERWISE; BUT YOU CANNOT SPECIFY OTHERWISE WITH RESPECT TO YOUR "PERSONAL REPRESENTATIVE" UNDER SUBPARAGRAPH D (iii).)

3. ( ) This power of attorney shall become effective on

[DATE]

(NOTE: INSERT A FUTURE DATE OR EVENT DURING YOUR LIFETIME, SUCH AS COURT DETERMINATION OF YOUR DISABILITY OR A WRITTEN DETERMINATION BY YOUR PHYSICIAN THAT YOU ARE INCAPACITATED, WHEN YOU WANT THIS POWER TO FIRST TAKE EFFECT.)

(NOTE: IF YOU DO NOT AMEND OR REVOKE THIS POWER, OF IF YOU DO NOT SPECIFY A SPECIFIC ENDING DATE IN PARAGRAPH 4, IT WILL REMAIN IN EFFECT UNTIL YOUR DEATH; EXCEPT THAT YOUR AGENT WILL STILL HAVE AUTHORITY TO DONATE YOUR ORGANS, AUTHORIZE AN AUTOPSY, AND DISPOSE OF YOUR REMAINS AFTER YOUR DEATH, IF YOU GRANT THAT AUTHORITY TO YOUR AGENT.)

4. ( ) This power of attorney shall terminate on

my death

(NOTE: INSERT A FUTURE DATE OR EVENT, SUCH AS COURT DETERMINATION THAT YOU ARE NOT UNDER A LEGAL DISABILITY OR A WRITTEN DETERMINATION BY YOUR PHYSICIAN THAT YOU ARE NOT INCAPACITATED, IF YOU WANT THIS POWER TO TERMINATE PRIOR TO YOUR DEATH.)

(NOTE: YOU CANNOT USE THIS FORM TO NAME CO-AGENTS. IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN PARAGRAPH 5.)

5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent:

[ALTERNATIVE POWER OF ATTORNEY]

For purposes of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person, or the person is unable to give

prompt and intelligent consideration to health care matters, as certified by a licensed physician.

(NOTE: IF YOU WISH TO, YOU MAY NAME YOUR AGENT AS GUARDIAN OF YOUR PERSON, IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED. TO DO THIS, RETAIN PARAGRAPH 6, AND THE COURT WILL APPOINT YOUR AGENT IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. STRIKE OUT PARAGRAPH 6 IF YOU DO NOT WANT YOUR AGENT TO ACT AS GUARDIAN.)

6. If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed_____

[NAME]

The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence. The undersigned witness certifies that the witness is not: (a) the attending physician or mental health services provider or a relative of the physician or provider; (b) an owner, operator, or relative of an owner or operator of a health care facility in which the principal is a patient or resident; (c) a parent, sibling, descendant, or any spouse of such parent, sibling or descendant of either the principal or any agent or successor agent under the foregoing power of attorney, whether such relationship is by blood, marriage, or adoption; or (d) an agent or successor agent under the foregoing power of attorney.

Signed_____

(Witness Signature)

_____

(Print Witness Name)

_____

(Street Address)

_____

(City, State, ZIP)

(NOTE: YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.)

Specimen signatures of agent (and successors).

I certify that the signatures of my agent (and successors) are correct.

_____ (agent)

_____ (principal)

_____ (successor agent)

_____ (principal)

_____ (successor agent)

_____ (principal)

(NOTE: THE NAME, ADDRESS, AND PHONE NUMBER OF THE PERSON PREPARING THIS FORM OR WHO ASSISTED THE PRINCIPAL IN COMPLETING THIS FORM IS OPTIONAL.)

_____ (Name of Preparer)

_____ (Street Address)

_____ (City, State, ZIP)

_____ (Phone Number)