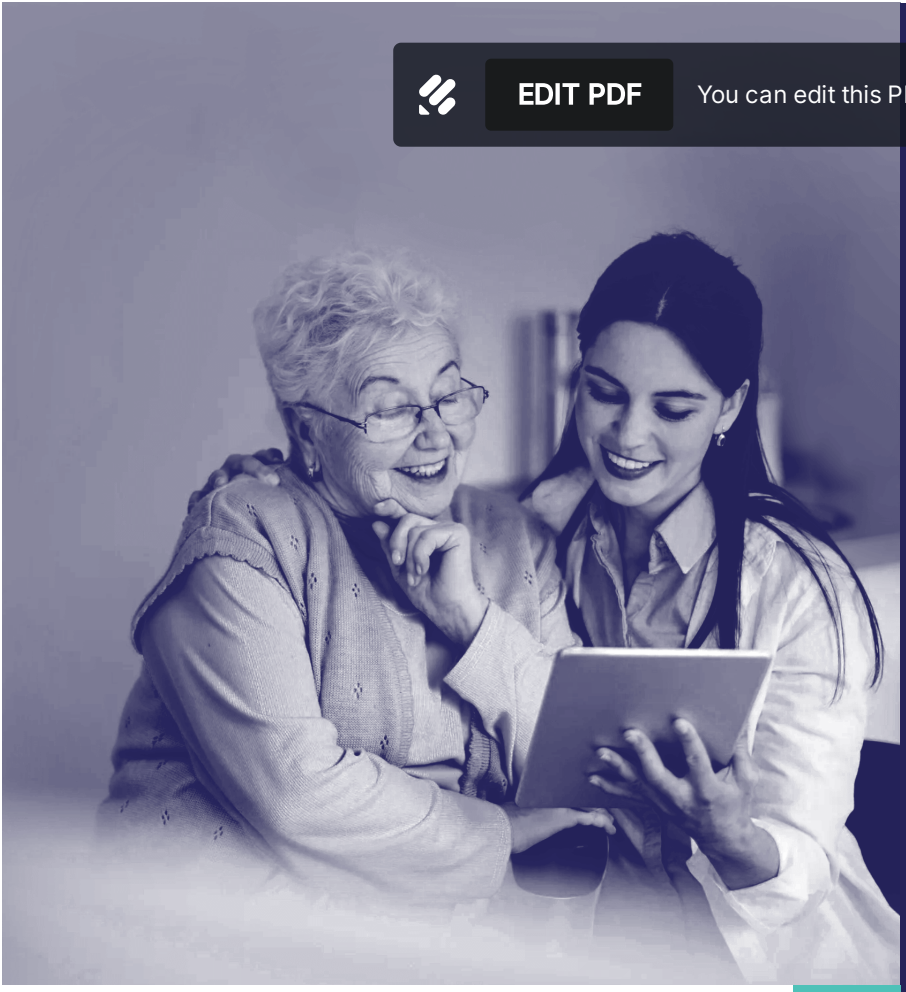

ACME CARE
Medical Clinic

MEDICAL POWER OF ATTORNEY

ACME CARE Medical Clinic
3147 Patterson Street, Houston, TX, 77002

info@acmecare.com - www.acmecare.com
(123) 1234567

Medical Power of Attorney Form

KNOW ALL MEN BY THESE PRESENTS:

I, _____ _____, a resident of _____, _____ _____, state of _____ (hereinafter known as "Principal"), hereby appoint as agent, _____ _____, whose residence is at _____ _____ _____ state of _____, to make any of the following medical decisions on my behalf, with exceptions to limitations that I may provide here in this document:

Limitations

In the event of the effectivity of this power of attorney, the Agent may be reached via the following:

Phone Number

Email

Alternate Agent

Name of Alternate Agent

Address of Alternate Agent

Phone Number

Email

Period of effectivity
This power of attorney shall be effective during the following:

Effectivity Start

- ☐ Upon Mental Disability of Principal
- ☐ Immediately

Effectivity End

- ☐ Upon death of the principal, unless powers is granted to Agent post-death authority provided in this power of attorney superseding this limitation.
- ☐ On a specific date provided

Date

Storage Location of Document and Copies

Post Death Authority of Agent

- ○ Agent has powers over the remains of the Principal in case of the latter's death in terms of organ donation, autopsy, and direct disposition of the remains.
- ○ Agent has powers over the remains of the Principal in case of the latter's death in terms of organ donation only.
- ○ Agent has powers over the remains of the Principal in case of the latter's death in terms of organ donation, autopsy, and direct disposition of the remains
- ○ Agent has powers over the remains of the Principal in case of the latter's death in terms of autopsy, and direct disposition of the remains

Exceptions

Organ Donation

Governing Law

This Power of Attorney shall be construed and governed by the laws of the state of _____.

Appointment of Alternate Agent

If my agent appointed above is unable or unwiling to serve as my agent, I appoint the following person(s) to serve as agents in the order set foth below with the authority to make health care decisions on my behalf as provided herein:

A. First Alternate Agent

Name: _____

Address: _____

Phone: _____

B. Second Alternate Agent

Name: _____

Address: _____

Phone: _____

Original and Copies of this Document

The original document is/will be filled in the following place:

I have/will provided copies of my medical power of attorney to the following:

Duration

Unless stated otherwise herein, this document shall remain in effect until I revoke it. I understand that I cannot revoke this document during the time I am considered incompetent.

(if applicable)

This power of attorney shall expire on .

Principal

Date Signed

Agent

Date Signed

Alternate Agent 2 (if applicable)

Date Signed

Alternate Agent

Date Signed

Acknowledgement of Witnesses (if required)

I hereby declare that as a witness, I am not appointed as an agent or alternate agent in this medical power of attorney. I declare that I am not, in any way, related to the principal by consanguinity or affinity. I am not an attending physician, a member of the physician's staff, or associated with a health care facility or its affiliates giving direct care to the principal. I have no claims whatsoever to the estate of the principal.

First Witness

Date Signed

Second Witness

Date Signed

Please note that witness signature is not required in every state. Please fill this section with regards to the requirements of the state where this power of attorney will be in force.

NOTARY ACKNOWLEDGEMENT (if required)

STATE OF _____,

_____ County, ss.

Subscribed and sworn to before me on this _____ day

of _____, _____, by _____, as a maker of this Medical Power of Attorney, who provided government-issued identification with photo as proof of identity to be the above-named person in the document, and in my presence executed the foregoing instrument and acknowledged that this was executed the same as his/her same act and deed.

_____

Notary Public

My commission expires on

Please note that notarization is not required in every state. Please fill this section with regards to the requirements of the state where this power of attorney will be in force.

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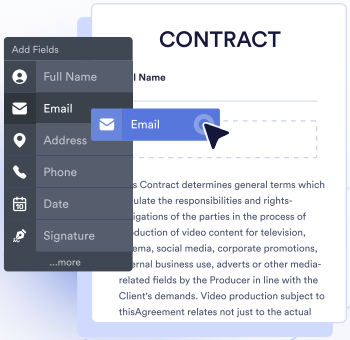

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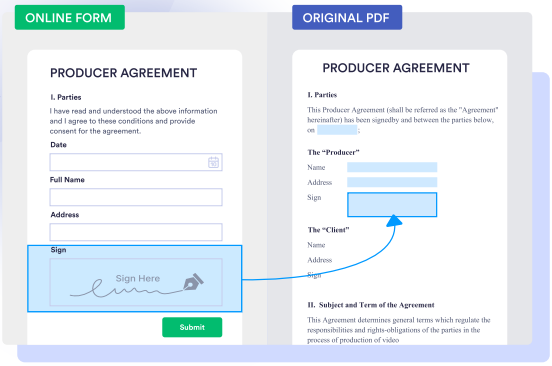

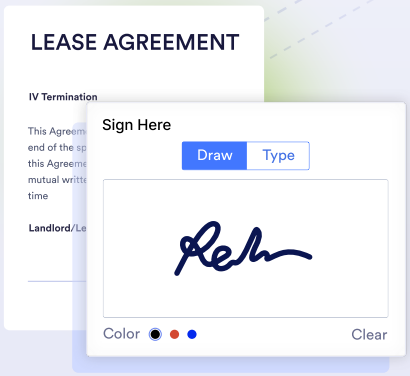

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