Medical Directives LLC

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Thank you for downloading the PDF-fillable form for your Medical Directive, Advance Medical Directive, or Medical Power of Attorney. The process is very straightforward:

1. Choose the subscription type you want and pay online. We use paypal for all credit card processing and NEVER store your Credit Card Information.
2. Download the form to your computer.
3. Fill it out on your computer and print it.
4. Take the filled-form to your favorite notary (or your witnesses) and have it notarized or witnessed.
5. Fax your paperwork to 866-300-7388. If you want to email it instead, please SCAN all to PDF utilizing 200 DPI scan settings, making 1 PDF file, and email to forms@medicaldirectives.net
6. Your Retrieval Card is emailed out to you within 24 hours of receiving your medical directive. If you lose it or need another one, you can generate one easily on our web portal .

Here is the form for the state you selected. Please do not fax back any instruction sheets. We do not require a coversheet when you fax.

ARKANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(Arkansas Statute Sec 20-13-104)

I, _____, of _____, City of _____, County of _____, Arkansas, hereby make, constitute and appoint _____, whose address is _____ _____ to act as my agent or attorney in fact, to make health care and related personal decisions for me as authorized in this document. Should _____ for any reason be unable or unwilling to act, temporarily or permanently, then I appoint _____, of _____as such agent/attorney in fact, with the same authority.

This Durable Power Of Attorney is made pursuant to the ***Arkansas Durable Power of Attorney for Health Care Act (Ark. Code Ann. § 20-13-104)***, and I do hereby designate and appoint _____ as my agent, or attorney in fact, to make decisions regarding my health care during periods when my health care provider has determined that I lack capacity to decide for myself. Specifically, and not to limit any other rights prescribed under the Act, my attorney-in-fact shall have the power to have access to my medical records for treatment or payment decisions; to disclose medical records to others for purposes of treatment, payment, or health care operations; to employ and discharge physicians; to consent to or refuse to consent to medical procedures, including the withholding or withdrawal of life-sustaining treatment, and nutrition and hydration, according to my wishes expressed in my Living Will, or, if my wishes are unclear under the then existing circumstances of my medical condition, then upon consideration of my best interests as determined by my physician in consultation with my agent; to admit me to hospitals, including psychiatric hospitals, nursing homes, or hospice care; and to sign all appropriate forms, consents and releases in connection with any of said matters. . If I should either (1) have an incurable or irreversible condition that will cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment; or (2) if I should become permanently unconscious, my health care agent and any alternate health care agent shall also have the authority to make decisions regarding the providing, withholding or withdrawing of life sustaining treatment pursuant to the *Arkansas Rights of the Terminally Ill or Permanently Unconscious Act.*

If _____ resigns, or is not able or available to make health care decisions for me, or if an agent named by me is divorced from me or is my spouse and legally separated from me, I appoint _____ as successor, with all of the rights and powers and authority herein stated. The term "health care" shall have the meaning set forth in *Ark. Code Ann. § 20-13-104(c)*. This Durable Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity.

Optional Instructions:

If the health care agent I appoint is unable, unwilling or unavailable to act as my health care agent, then I appoint:

_____

(Name, home address and telephone number of alternate agent)

_____ as my alternate health care agent.

Signed this _____ day of _____, _____.
(Day) (Month) (Year)

Signature _____

Address _____

_____

Statement by Witnesses (must be 18 or older):

I declare that the person who signed this document appeared to execute the durable power of attorney for health care willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

1) Witness _____
(Sign and Print name)
Address _____
_____

2) Witness _____
(Sign and Print name)
Address _____
_____