Durable Power of Attorney for Health Care

353 Fairmont Boulevard, Rapid City, SD 57701

Fill out this document carefully. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This document will be in effect unless or until you revoke it. You may change or revoke this document at any time by telling your doctor and other healthcare providers. You should give copies of this document to your family, your doctor and your health care facility. This form is optional. If you choose to use this form, the form has a signature line for you and a notary.

l,		, apr	oint
(Principal/Patient)		(Birthday)	oint (Decision Maker/Agent)
•		se of making healthcare decis my Attorney-In-Fact, I appoir	ions on my behalf. In the event the person named
		as my Attorney-In-Fact. In ny Attorney In Fact, I appoint	the event both of the previously named persons are
		_ as my Attorney-In-Fact. Thisd Law §§ 59-7-2.1-2.8.	Power of Attorney shall become effective upon my
I grant my Attor	ney-In-Fact the p	ower to:	
(Initial)M below:	ake any and all hea	Ith care decisions on my beha	If, including each of the powers identified in items 1-7
C)R		
2) 3) 4) 5) 6) 7)	Reject care or treatment recommended by a healthcare provider in accordance with my previously stated wishes. Authorize a healthcare provider to withhold care or treatment when such care or treatment would prolong my suffering. Authorize artificial nutrition to be withheld or withdrawn. Authorize artificial hydration to be withheld or withdrawn. Other /Additional Instructions (specify):		
Dated this, the	day of	, 20	(Principal/Patient)
State of South Da	kota)) ss		(Principal/Patient)
		_,20, ve, personally appeared befor ecuted the same for the purpo	known to me or satisfactorily me, a Notary Public with the State of South Dakota, ses stated herein.
Notary Public			Soal
My commission expires			Seal
Produced by Regional Heat Learning & Dev	ilth elopment Department		