DESIGNATION OF PATIENT ADVOCATE

KNOW ALL MEN by these presents that I, _____ a resident of , Michigan, being of sound mind, designate _____ a resident of , Michigan as my Patient Advocate, and _____, as Alternate Patient Advocate, pursuant to Act No. 312 of the Public Acts of 1990 to exercise such powers concerning my care, custody and medical treatment decisions as are permitted pursuant to said Act; including those specific powers enumerated below. The authority conferred by this Designation shall be exercisable only in the event that I am unable to participate in medical treatment decisions. My treating physical or other licensed physician or licensed psychologist shall determine upon an examination whether I am unable to participate in medical treatment decisions, which determination shall be in writing, made a part of my medical record and reviewed not less than annually.

With respect to my care, custody and medical treatment my advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of my person, including, but not limited to:

1. Access to Medical Records. I authorize and direct that my Patient Advocate have complete access to and control over my medical and personal information, records, notes, orders and reports; to access my medical records, obtain individually identifiable health information, and act as my personal representative under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and my authorized representative under the Medical Records Access Act, MCL 333.26261 et seq.; to disclose the contents of my medical records to others; and to execute medical releases and any other documents required to carry out the powers set forth herein. This power is meant to be an unlimited, full, and complete authorization for the release of any and all protected medical information as defined under HIPAA and the Medical Records Access Act, as amended, and under the rules and regulations thereof, and covers all protected information from primary and secondary providers, health plans, health care clearinghouses, emergency services, financial and administrative transactions, and business associates. It is understood that the patient advocate to whom this power is given has my permission to use and disseminate this information in his or her sole discretion.

2. Employment and Discharge of Medical Personnel. My Patient Advocate shall have full authority to employ and discharge physicians, nurses, therapists, and any other care providers and to pay them reasonable compensation.

3. Consent to or Refusal of Treatment. My Patient Advocate shall have full authority to give an informed consent or an informed refusal on my behalf with respect to any medical care; diagnostic, surgical, or therapeutic procedure; or other treatment of any type or nature, including life-sustaining treatments such as artificial nutrition and hydration and generally to exercise such powers concerning my care, custody and medical treatment that I could have exercised on my own behalf had I been able.; to authorize my admission to or discharge from (even against medical advice) any hospital, nursing home, care facility, or hospice care; to contract on my behalf for any health care–related service or facility, without my patient advocate incurring personal financial liability for such contracts; to hire and fire medical and other support personnel responsible for my care; on behalf of me and my estate, to release from liability all persons and entities who act in good-faith reliance on instructions given by my patient advocate and to execute any documents, such as a refusal of treatment form or a do-not-resuscitate order, that a physician or a facility may require to carry out my wishes regarding medical treatment ;**[Optional: My patient advocate may make an anatomical gift of all or part of**

my body and this authority remains exercisable after my death.]

4. Acknowledgment and Expression of Intent. In making and executing this instrument I specifically authorize my Patient Advocate to withhold or withdraw treatment which would allow me to die and acknowledge that I am well aware that such a decision could or would result in my death. Death is a much a reality as birth, growth, maturity and old age. If the time comes when I can no longer take part in medical decisions respecting myself, I desire that this statement stand as an expression of my wishes, while I am still of sound mind. Should the situation arise in which there is no reasonable expectation of my recovery from physical or mental disability, I request that I be allowed to die and not to be kept alive by artificial means or heroic measures. I do not fear death itself as much as the indignities of deterioration, dependency and hopeless pain. I, therefore, ask that medication be mercifully administered to me to alleviate suffering even though this may hasten the moment of my death.

I further request that if at anytime I should have an incurable injury, disease or illness certified to be a terminable condition by one or more physicians and where the use or application by any person of artificial, extraordinary, extreme or radical medical or surgical means or procedures calculated to prolong my life would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally and with dignity.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I executed this directive after careful consideration and with the understanding that any person, hospital, or medical institution which acts in reliance on and in compliance with this directive shall be immune from liability otherwise arising out of such failure to use or apply artificial, extraordinary, extreme or radical medical or surgical means or procedures calculated to prolong my life.

I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

5. Signing of Requisite Documents. My Patient Advocate is further authorized to sign, execute, and deliver such waivers, medical authorizations and such other writings as may be required to permit or authorize care which I may need, or to discontinue care that I am receiving.

IN WITNESS WHEREOF, I have executed this Designation of Patient Advocate this _____ day of _____, 2008.

The undersigned have signed as witnesses to this Designation of Patient Advocate which was signed in our presence. The declarant appears to be of sound mind and to be making this designation voluntarily and under no duress, fraud, or undue influence. We certify that neither of us is the declarant's spouse, parent, child, grandchild, sibling, presumptive heirs, known devisee at the time of this witnessing, physician or patient advocate, nor are either of us an employee of a life or health insurance provider for the declarant or of a health facility treating the declarant, or an employee of a home for the aged where the declarant resides.

Witness:

_____

ACCEPTANCE BY PATIENT ADVOCATE

(A) This designation shall not become effective unless the patient is unable to participate in treatment decision.

(B) A patient advocate shall not exercise powers concerning the patient's care, custody and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

(C) This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

(D) A patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(E) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights and responsibilities.

(F) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.

(G) A patient may revoke his or her designation at any time or in any manner sufficient to communicate an intent to revoke.

(H) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

(I) A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public

Health Code, Act. 368 or the Public Acts of 1978, being Section 333.20201 of the Michigan Complied Laws.

I understand the above conditions and I accept the designation as Patient Advocate for
Dated:_____.Signed:

Dated:_____.Signed:_____