

**ARKANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE**  
*(Arkansas Statute Sec 20-13-104)*

I, \_\_\_\_\_, 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 \_\_\_\_\_, 20\_\_\_\_.

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 (Print Name) \_\_\_\_\_

Witness Signature \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

2 Witness (Print Name) \_\_\_\_\_

Witness Signature \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

**DISCLAIMER:** The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.