SICHC-1

APPOINTMENT OF HEALTH CARE REPRESENTATIVE (PAGE 1 OF 1)

Patient Name

Pursuant to Indiana Code 16-8-12 et seq. I hereby appoint:

Name	Relationship to Patient (relative, friend, etc.)
Address	
Home Telephone Number ( )	Work Telephone Number ( )

as my representative to act in my behalf on all matters concerning my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery , and /or placement in health care facilities, including extended care facilities. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care.

I hereby give the following instructions to my representative (optional):

1.) ______________________________

____

____

2.) ______________________________

____

____

I authorize all health care providers to rely upon consents and authorizations provided by my representative, and I ratify all that my representative shall do by virtue of this appointment. I agree to be financially responsible for health care services performed in reliance upon consents executed by my health care representative.

Patient Signature	Date
Witness (Adult other than Representative)	Date

APPOINTMENT OF HEALTH CARE REPRESENTATIVE (PAGE 1 OF 1)