Power of attorney to render medical treatment by article 16 of the Patient Rights Law

1. I, _____, the undersigned, bearer of identification No. _____ whose address is _____ hereby appoints Mr./Mrs. _____ bearer of identification No. _____ whose address is _____, phone No. _____
   (and Mr./Mrs. _____ bearer of identification No. _____ whose address is _____, phone No. _____) jointly and severally, to be my warrantee to agree/ refuse to receive medical treatment in my place by provisions of article 16 of the Patient Rights Law 1996. (It is not mandatory to appoint two persons. Strike out the unnecessary)
2. This power of attorney will enter into effect if and when, for any reason whatsoever, physical or mental, I will be unable to express my opinion or give an informed consent to a medical treatment that I may require.
3. This power of attorney will be valid for the following matters*:
   [ ] to agree/ refuse in my name to any procedure or medical treatment I may require, including treatment requiring a written consent.
   [ ] agree/ refuse in my place to receive only the medical treatments listed below:
   _____
   _____
   _____
   (should there be treatments that are not listed above, a court order would be required)
   [ ] to request and receive medical information and/or opinion from any practitioner who has examined, treated or is treating me and from any medical institute where I was or am treated when this information may be required for reaching a decision pertaining to my treatment.
   [ ] to decide regarding my admission into a medical or nursing institute, including long-term hospitalization subject to any lawful instruction or to the following limitations: _____
   _____ (Please specify.)
   [ ] to represent me before an ethics board in accordance with the Patient Rights Law, should the need arise.
4. Despite the aforesaid, the warrantee may not perform any financial action or undertake any financial liability in my name and will not be entitled to waive in my name of medical secrecy, unless this would become essential for the purpose of receiving medical treatment that I may need and for which, my warrantee is required to make a decision.

5. Terms and limitations applicable on the power of attorney:
   _____
   _____
   _____
6. This power of attorney will not constitute as a waiver of my rights and I will be entitled to retract or cancel the appointment at any time prior to entering into effect or pursuant to that should I be able to express my opinion on the subject or by giving a **written** notice to my warrantee or caregiver or any medical institute where a copy of the power of attorney is stored, as the matter may be.
   Under special circumstances in which it would be impossible to receive from me a written notice, I may give an oral notice of cancellation of the power of attorney before two witnesses, as long as my words and the testimony are recorded in writing as close as possible to the time of its giving.
7. I relinquish any action or claim I may have against a caregiver and any person as a result of bona fide reliance on this power of attorney while a notice of its cancellation was not rendered.
8. The power of attorney will expire on its own ten years from this day or*:
   [ ] on _____ or
   [ ] in the event of: _____
   at the earlier date, unless renewed by me or entered into effect and was used as mentioned in the foregoing section 2, before the aforesaid date.

Being of clear mind and out free will and without coercion or duress, in witness whereof I affixed my signature at _____ on this _____ day of the month of _____ in the year _____.

Patient's Signature: _____

Consent of the warrantee

I, _____, the undersigned, bearer of identification No. _____ give my consent to be appointed the foregoing patient for the matter of rendering medical treatment by article 16 of the Patient Rights Law and confirm that I have read the power of attorney and understood my role and authorities.

I am aware of the fact that I am required to inquire in advance, as much as possible, about the wishes of the patient in regards to the medical treatments according to various conditions and to uphold his/her wishes in fidelity. I am aware of the fact that my discretion and capability of taking action are limited to the subjects mentioned in the power of attorney and subject to the patient's instructions as far as those are to be given to me in advance, and for the patient's well-being.

Date: _____ Warrantee's signature: _____

Signature by a verifying witness
(physician, social worker, nurse, psychologist or lawyer)

I confirm that the aforementioned signed the power of attorney in front of me, pursuant to my verification of their identity to the best of my ability and I am under the impression that they comprehend the significance of the document.

Date: _____ Stamp: _____ Signature: _____

** Mark X where appropriate

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