NORTH CAROLINA
HEALTH CARE POWER OF ATTORNEY

I. DESIGNATION OF HEALTH CARE AGENT: I, Full Name of Patient, being of sound mind, hereby appoint the following person to serve as my health care agent to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent shall serve alone.

Health Care Agent Name
Address
Primary Telephone No.:
Alternate Telephone No.:

II. EFFECTIVENESS OF APPOINTMENT: My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if two or more physicians, one of whom shall be my personal physician, determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

III. REVOCATION. Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

IV. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

a. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.

b. Employing or discharging my health care providers.

c. Consenting to an authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.

d. Consenting to an authorizing my admission to and retention in a facility for the care or treatment of mental illness.

e. Consenting and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as “shock treatment.”

f. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under this authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.

g. Authorizing the withholding or withdrawal of life-prolonging measures.

h. Providing my medical information at the request of any individual acting as my attorney-in-fact under a durable power of attorney or as a Trustee or successor Trustee under any Trust Agreement of which I am a Grantor or Trustee, or at the request of any other individual whom my health care agent believes should have such information. I desire that such information be provided whenever it would expedite the prompt and proper handling of my affairs or the affairs of any person or entity for which I have some responsibility. In addition, I authorize my health care agent to take any and all legal steps necessary to ensure compliance with my instructions providing access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorneys' fees against anyone who does not comply with this health care power of attorney.

i. To the extent I have already made valid and enforceable arrangements during my lifetime that have not been revoked, exercising any right I may have to authorize an autopsy or direct the disposition of my remains.

j. Taking any lawful actions that may be necessary to carry out these decisions, including but not limited to: (i) signing, executing, delivering, and acknowledging any agreement, release, authorization, or other document that may be necessary, desirable, convention, or proper in order to exercise and carry out any of these powers; (ii) granting released of liability to medical providers or others; and (iii) incurring reasonable costs on my behalf related to exercising theses powers, provided that this health care power of attorney shall not give my health care agent general authority over my property or financial affairs.

V. SPECIAL PROVISIONS AND LIMITATIONS. Limitations about Artificial Nutrition or Hydration: In exercising the authority to make health care decisions on my behalf, my health care agent shall have the authority to withhold artificial nutrition (such as through tubes) and shall have the authority to withhold artificial hydration (such as through tubes).

VI. GUARDIANSHIP PROVISION. If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5).

VII. RELIANCE OF THIRD PARTIES ON HEALTH CARE AGENT.

a. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors,

assigns, or personal representatives, for actions or omissions in reliance on that authority or those representations.

b. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or action taken under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my consent and shall have the same validity and effect as if I were present and exercised the powers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

VIII. MISCELLANEOUS PROVISIONS.

a. **Revocation of Prior Powers of Attorney.** I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may related to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.

b. **Jurisdictions, Severability and Durability.** This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.

c. **Health Care Agent Not Liable.** My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns and person representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.

d. **No Civil or Criminal Liability.** No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as defense.

e. **Reimbursement.** My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

IX. SPECIAL INSTRUCTIONS.

I am a Christian who holds to the conviction that no man who is not my husband should ever access or see parts of my body that are covered by a two piece bathing suit. This means that no male medical personnel may ever access or see my intimate body parts. My religious convictions have to be accommodated.

A. INTIMATE MEDICAL PROCEDURES

1. No male gynecologists may ever treat me or be a part of my medical care under any circumstances.
2. No gynecological procedures can ever be done on me unconscious or if I am even a little drowsy. I must be fully awake and alert with no sedation for those procedures. I understand that there is a small risk that may cost my life in an emergency and I accept this risk. My modesty and bodily privacy is number 1 priority.
3. No males shall be present for any procedures that could uncover my body parts that are covered by a two-piece bathing suit. ONLY female medical personnel can be present. There must be a sign on the door that says No Males allowed. I expect all male medical personnel to follow the same standards as men in the general population. They must respect my dignity by never touching or seeing my intimate body parts covered by a two-piece bathing suit. If they do not follow those standards, I will definitely press charges for sexual assault and take legal action.
4. No intimate procedures (that involve body parts that are covered by underwear and bra) such as colonoscopies bladder cystoscopies, any gynecological procedures, etc. can ever be done without my express written consent. They must be done by only female medical personnel. No males can be present for any amount of time.
5. No urinary catheter may ever be inserted unless it is with my consent and for a good reason such as severe urinary retention. This must be the last resort and if one is required, only a female can do it and she must wash her hands thoroughly in front of me.
6. No rectal exams can ever be done.
7. No transvaginal ultrasounds and only abdominal ultrasounds.
8. I do not want assistance with bathing or personal care at all. But if for some reason, I am in a position I need help with personal care, only females can assist. I want my dignity to be protected as much as possible during assisted personal care. I would like to wear Honor Guard garments by Dignity Resource Council if assisted bathing is required.
9. I desire to wear my own clothes as much as possible. I want to avoid a medical gown as much as possible.

B. I DO NOT Consent to:

1. I cannot have Penicillin since I'm allergic to it.
2. I do not consent to any opioids that could render me incapacitated for even a few minutes.
3. No general anesthesia or sedation for me ever. If I ever have surgery, I only accept local anesthesia or regional anesthesia with no sedation. This means I must be fully awake for the surgery. I **DO NOT** consent for use of Nitrous oxide (laughing gas), Versed, Midazolam, any benzodiazepines, Propofol, or any types of sedatives in any AMOUNT or at ANYTIME EVER that could incapacitate me. If those wishes are violated, I will pursue legal action.
4. No IV may be inserted without my personal advocate present to ensure that no sedatives are put in my IV. I would be fine with fluids or antibiotics intravenously.

C. SURGERIES

1. For all surgeries, I must have a personal advocate (person I choose) not employed by the hospital present in Pre-OP, the operating room, and post-Op. If the hospital is not willing to accommodate this request, the surgery must be cancelled and I will go somewhere else. This personal advocate will wear scrubs and sit in the operating room to advocate for me and make sure that my requirements are not ignored.
2. I must be able to wear underwear and bra with no metals for surgeries that do not involve private parts such as hand, knee, etc. For procedures that require access to the groin area or hip, I must wear COVR Medical garments. If the medical facility is not willing to accommodate those requirements, the procedure cannot take place.

D. HOSPITALIZATION

1. It is my desire to avoid hospitalization. This should be the last resort. If for some reason, I require hospitalization, I must have a personal advocate (not employed by the hospital) with me the entire time of my hospitalization. If the hospital is not willing to accommodate my wishes for a personal advocate of my choice to be with me the entire time, I will go home even if I am in critical condition. Or I will be transferred to another hospital that is willing to accommodate my requirement for a personal advocate to be with me at all times. It is especially important for the personal advocate to be with me at all times since I am completely deaf.
2. There must be a "No Male Personnel" sign on my door if I require hospitalization. No male nurses can treat me in my room or when I am vulnerable such as drowsy or sleepy. I am fine with male nurses doing simple things such as blood pressure checks in the presence of my personal advocate

who is not employed by the medical facility. But they must be careful to not touch any parts of my body that are covered by a two-piece bathing suit. If they do not follow that rule, I will press charges and take legal action.

E. TRAUMA / ER REQUIREMENTS: My clothes may not be removed or cut off by paramedics or anyone in ER. They must work with my clothes and protect my dignity. If I am unconscious, it is my request for all paramedics and medical professionals in ER to be patient and let me wake up with my clothes on even if they are soaked or dirty. I realize this is risky and I accept this risk.

F. NURSING HOME. I may never be placed in a nursing home for any reason. If I got to this point, I want my family and friends to set up a GoFundMe Fundraiser page to raise money for home health care. I must remain in my home. Any therapy must be done at my home or another facility during the day.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

This the _____ day of _____, 2022.

_____

Full Name of Patient, Principal

I hereby state that the principal, Full Name of Patient, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing Health Care Power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: _____, 2022 _____

Signature of Witness No. 1

Date: _____, 2022 _____

Signature of Witness No. 2

STATE OF NORTH CAROLINA
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this day by: Full Name of Patient, _____ _____ and _____, the witnesses.

Date: _____, 2022.

_____
Notary Public Signature

_____
Typed or Printed Name

(Official Seal)

My Commission Expires: _____