Reset Form

RECORD OF HEALTH CARE REPRESENTATIVE

State Form 45600 (R3 / 5-19) / OGC 0022
FAMILY AND SOCIAL SERVICES ADMINISTRATION
OFFICE OF GENERAL COUNSEL

By Operation of IC 16-36-1-5(a)of Indiana's Health Care Consent Law, _____ , agrees to act
Name of Health Care Representative

as _____'s (referred to after this as "the incapacitated person") Health Care Representative.
Name of patient

I am at least eighteen (18) years of age. ☐ Yes ☐ No	I have the following relationship to the incapacitated person: *(The listing is a Hierarchy of Priority.)*
	☐ 1. Husband ☐ 2. Wife ☐ 3. Adult Child ☐ 4. Father ☐ 5. Mother
	☐ 6. Adult Brother ☐ 7. Adult Sister ☐ 8. Grandfather ☐ 9. Grandmother ☐ 10. Adult Grandchild
	☐ 11. Nearest adult relative in the next degree of kinship not listed above:

I understand that it is the opinion of the incapacitated person's attending physician that the incapacitated person is incapable of making a decision regarding the incapacitated person's own health care. A Physician's Statement is below.

To my knowledge, the incapacitated person has none of the following:
1. A health care representative either appointed by the incapacitated person or appointed by a Court, under IC 16-36-1-8;
2. a judicially appointed guardian; or
3. a power of attorney for health care.

As the incapacitated person's Health Care Representative, I understand that I am authorized to make decisions regarding any care, treatment, service or procedure to maintain, diagnose, or treat the incapacitated person's physical or mental condition. I agree to act in good faith and in the best interest of the incapacitated person.

I understand that a family member as a Health Care Representative, in that capacity, incurs no personal liability for the cost of the health care consented to or on behalf of the incapacitated person.

Signature of Health Care Representative	Date signed *(month, day, year)*
Printed name of Health Care Representative	

STATEMENT OF PHYSICIAN

It is my opinion that the above named patient is incapacitated regarding to making health care decisions for the following reasons:

Signature of Physician	Date signed *(month, day, year)*
Printed name of Physician	

Copy to: 1. Client File; 2. Health Care Representative