DURABLE POWER OF ATTORNEY

FOR HEALTH CARE DECISIONS

by

YOUR NAME SHOULD BE PRINTED OR TYPED HERE

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR ATTORNEY-IN-FACT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENT OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE CONSENT. REFUSAL OF CONSENT, OR WITHDRAWAL OF CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT OR PLACEMENTS THAT YOU DO NOT DESIRE.

2. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.

3. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THE POWER OF THE PERSON YOU DESIGNATE TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT WHICH WOULD KEEP YOU ALIVE.

4. UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST INDEFINITELY FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

5. NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED IF YOU OBJECT.

6. YOU HAVE THE RIGHT TO REVOKE THE APPOINTMENT OF THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THAT PERSON OF THE REVOCATION ORALLY OR IN WRITING.

7. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY GRANTED TO THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THE TREATING PHYSICIAN, HOSPITAL, OR OTHER PROVIDER OF HEALTH CARE ORALLY OR IN WRITING.

8. THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

9. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

10. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

1. DESIGNATION OF HEALTH CARE AGENT.

I, *YOUR NAME PRINTED OR TYPED HERE*, do hereby designate and appoint:

Name: *THE NAME OF YOUR AGENT SHOULD BE PRINTED OR TYPED HERE*,

Address: *YOUR AGENT'S ADDRESS SHOULD BE PRINTED OR TYPED HERE*,

Telephone Number: *YOUR AGENT'S PHONE # PRINTED OR TYPED HERE*, as my attorney-in-fact to make health care decisions for me as authorized in this document.

NOTE: Unless the person you designate as your attorney-in-fact is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: (1) your treating provider of health care, (2) an employee of your treating provider of health care, (3) an operator of a health care facility, or (4) an employee of a health care facility.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED.

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS.

NOTE: Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psycho surgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on his or her attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.

In exercising the authority under this durable power of attorney for health care, the authority of my attorney-in-fact is subject to the following special provisions and limitations (if none, so state:

IF YOU HAVE ANY SPECIAL PROVISIONS ADD THEM HERE. IF YOU DO NOT HAVE ANY, THEN WRITE THE WORD "NONE" HERE. ________________________________

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5. DURATION.

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

I wish to have this power of attorney end on the following date (if no expiration date, so state): *PROVIDE THE DATE YOU WANT THIS POWER OF ATTORNEY TO EXPIRE OR IF YOU DO NOT WANT THIS POWER OF ATTONEY TO HAVE AN EXPIRATION DATE THEN WRITE "NO EXPIRATION DATE" HERE.*

6. STATEMENT OF DESIRES.

NOTE: With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.

If any of the statements below reflect your desires, write your initials in the box next to the statement or statements you want.

1. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures.

2. If I am in a coma which my doctors have reasonably concluded is irreversible I desire that life sustaining or prolonging treatments not be used.
NOTE: if this box is initialed, you should also execute a declaration directing your physician to withhold or withdraw life-sustaining treatment.

3. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life sustaining or prolonging treatments not be used.
NOTE: if this box is initialed, you should also execute a declaration directing your physician to withhold or withdraw life-sustaining treatment.

4. Withholding or withdrawal of artificial nutrition or hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld.

5. I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.

NOTE: If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.

Other or Additional Statements of Desires:

IF YOU HAVE ANY ADDITIONAL STATEMENTS OR DESIRES THEN ADD THEM HERE. IF YOU DO NOT HAVE ANY, THEN WRITE THE WORD "NONE" HERE. ___________________

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7. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT.

NOTE: You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1, page 2, in the event that he or she is unable or unwilling to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.

If the person designated in paragraph 1 as my attorney-in-fact is unwilling or unable to make heath care decisions for me, then I designate the following person(s) to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternative Attorney-in-Fact:

Name: *THE NAME OF YOUR FIRST ALTERNATIVE AGENT PRINTED OR TYPED HERE*,

Address: *YOUR FIRST ALTERNATIVE AGENT'S ADDRESS PRINTED OR TYPED HERE*,

Telephone Number: *YOUR FIRST ALTERNATIVE AGENT'S PHONE # GOES HERE.*

B. Second Alternative Attorney-in-Fact: (IF YOU HAVE A SECOND ALTERNATIVE AGENT PROVIDE THAT INFORMATION! IF NOT, WRITE **N/A** ON EACH LINE)

Name: ***THE NAME OF YOUR SECOND ALTERNATIVE AGENT PRINTED OR TYPED HERE***,

Address: ***YOUR SECOND ALTNERNATIVE AGENT'S ADDRESS PRINTED OR TYPED HERE***,

Telephone Number: ***YOUR SECOND ALTERNATIVE AGENT'S PHONE # GOES HERE.***

8. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

9. OTHER POWERS. In addition to the authority herein granted to by my agent and attorney-in-fact, I also grant to my agent the right, power and authority as follows:

A. To petition a court of competent jurisdiction to appoint my Agent or to designate another suitable person or entity to act as the Guardian of my person and estate and to make any and all arrangements to provide for my health care and to determine whether such health care should be provided for in my name or through a nursing care facility;

B. To apply for, receive and otherwise sign any and all documents necessary to obtain any and all Medicare, Medicaid, medical insurance or other private or governmental benefits or assistance which is available to pay for or provide health care for me, and to appeal any denials by any private or commercial entities and governmental agencies;

C. To designate, appoint, hire or engage such other persons, including but not limited to physicians, nurses, home care personnel, therapists, accountants, attorneys, administrators or other persons necessary to carry out the matters provided for herein or to provide for my health care and treatment;

D. To participate in my care and treatment plan;

E. To transfer me to another hospital or jurisdiction for treatment or care, to include a hospice;

F. To refuse further chemotherapy or radiation;

G. To consent to experimental treatment;

H. To hire home health care or consent to my transfer to a hospice;

I. To control unwanted family intervention in my medical care or treatment of the decision to terminate continued care or treatment;

J. To return me to my home, if only to die there;

K. To purchase supplemental needs, such as electric wheel chairs, recreation needs, airline tickets for visits from family, etc.;

L. To establish a residence for me, such as a nursing home or assisted living facility;

M. To provide for my religious needs;

N. To purchase, maintain and dispose of household goods and effects;

O. To care or dispose of my pets;

P. To arrange for companionship for me;

Q. To initiate legal action on my behalf against health care providers, banks, financial institutions and insurers for non-compliance with this and other powers of attorney, directives to physicians, or denial of insurance coverage;

R. To execute, acknowledge, deliver and record any documents and instruments which are reasonably necessary to perform any acts authorized by this Power of Attorney, including but not limited to, authorizations, consent for treatment, declinations of treatment, releases and any other documents pertaining to my health and medical care. Any documents and instruments which are reasonably necessary to perform the acts authorized by this Power of Attorney will be valid when executed by my Agent; and,

S. To do anything else that adds dignity and control to the process of my illness or death.

10. HIPAA RELEASE AUTHORITY. I authorize my Agent to examine my medical records and to consent to their disclosure unless I have limited this power elsewhere in this Durable Power of Attorney for Health Care Decisions. Specifically, my authorization to release my medical records shall include but not be limited to the following:

A. When, in the process of determining the incapacity of either a Grantor or a Trustee, all individually identifiable health information and medical records may be released to my Agent, to include any written opinion relating to my incapacity that my Agent may have requested. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act, 42 USC 1320d and 45 CFR 160-164.

B. Any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other health care provider, any insurance company, the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services shall give, disclose and release to my Agent, without restriction, identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnoses and/or treatment of HIV/AIDS, mental illness and drug or alcohol abuse.

C. Any psychologist, psychiatrist, licensed therapist or other healthcare provider involved with diagnoses or therapy or other treatment which pertains to my mental health shall give, disclose and

release to my Agent any and all individually identifiable health information and medical records involving any past, present or future mental health condition. This specific authorization includes but is not limited to psychotherapy noted defined by HIPAA as "notes recorded in any medium by a mental health professional documenting or analyzing the contents of conversation during a private counseling session", as well as medication prescription and monitoring, counseling session start and stop times, modalities and frequencies of treatment, results of clinical tests, and any summary of diagnosis, functional status, treatment plans, symptoms, prognosis or progress. In order to permit my Agent to assume control in the event of my incapacity, I hereby waive any medical privilege which applies to the extent necessary to allow medical providers to execute any affidavit or to provide other information necessary to determine whether or not I am able to act rationally and prudently in my medical matters. My Agent shall have the same rights of access to these notes as I am entitled to under the provisions of HIPAA and under applicable state law.

11. GUARDIANSHIP. If any person, agency or entity seeks to appoint themselves or another as my guardian or if it becomes necessary or required for a conservator or guardian of my person and/or my estate to be appointed for me, I nominate ***YOUR AGENT (ATTORNEY-IN-FACT) CAN ALSO BE APPOINTED AS YOUR GUARDIAN OR YOU CAN CHOSE SOMEONE ELSE. THAT PERSON'S NAME GOES HERE*** to act and serve as guardian of my person and/or estate.

NOTE: THIS POWER OF ATTORNEY FOR HEALTH CARE WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS DATED AND SIGNED BY YOU AND EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC. NEITHER WITNESS CAN BE THE PERSON YOU NAME AS YOUR AGENT/ATTORNEY-IN-FACT FOR THIS POWER OF ATTORNEY.

NOTE: YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY EITHER IN THE PRESENCE OF TWO QUALIFIED WITNESSES OR A NOTARY PUBLIC.

I sign my name to this Durable Power of Attorney for Health Care Decisions on ______________________________, 20____ at ________________________, Nevada.

day and month printed here year City such as Las Vegas or Reno

Signature: ____

Your signature here, but sign only in the presence of two witnesses or a Notary

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Nevada)

) ss.

County of ________)

On this _____ day of ____________, in the year 20___, before me, the undersigned Notary Public for the State of Nevada, personally appeared, and who is personally known to me or provided to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument, and acknowledge that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

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NOTARY PUBLIC

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IF NOTARY IS NOT USED, THEN SIGN THIS DOCUMENT IN FRONT OF AT LEAST TWO WITNESSES WHO WILL SIGN BELOW. THESE WITNESSES MUST NOT BE ANY OF THE PERSONS TO WHOM YOU GAVE THE POWER TO BE YOUR ATTORNEY-IN-FACT.

STATEMENT OF WITNESSES

NOTE: You should carefully read and follow the witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the attorney-in-fact, (2) a provider of health care, (3) an employee of a provider of health care, (4) the operator of health care facility, (5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign (when a notary public is not used).

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of a health care facility.

______________________________ ______________________________

Signature (of witness) Street Address or P.O. Box (of witness)

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Printed Name (of witness) City, State & Zip Code (of witness)

Date: ______________________________

______________________________ ______________________________

Signature (of witness) Street Address or P.O. Box (of witness)

______________________________ ______________________________

Printed Name (of witness) City, State & Zip Code (of witness)

Date: ______________________________

NOTE: WHEN A NOTARY PUBLIC IS NOT USED, AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.

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I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: ____________________________________

(of witness)

Printed Name: __________________________________

(of witness)

Address: ____________________________________

(of witness)

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Date: ______________________

Signature: ____________________________________

(of witness)

Printed Name: __________________________________

(of witness)

Address: ____________________________________

(of witness)

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Date: ______________________

COPIES: You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.

(IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD CALL THE LAW OFFICES OF DEMPSEY, ROBERTS & SMITH, LTD., YOUR LEGALSHIELD PROVIDER LAW FIRM IN NEVADA AT (702) 388-4401 OR (800) 5664775 AND ASK ONE OF OUR ATTORNEYS FOR AN EXPLANATION).