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MEDICAL POWER OF ATTORNEY
DESIGNATION OF HEALTH CARE AGENT

I, FIELD(P), appoint:

Name: **FIELD(FIELD(MedicalPOA1))**

Contact Information: FIELD(AddressFIELD(MedicalPOA1)), FIELD(CityStateZipFIELD(MedicalPOA1)), FIELD(PhoneFIELD(MedicalPOA1))

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney for health care takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION MAKING AUTHORITY OF MY AGENT

The limitations on the decision making authority of my agent are as follows:

1. **Jewish Law to Govern Health Care Decisions**: I am Jewish. It is my desire, and I hereby direct, that all health care decisions made for me (whether made by my surrogate, a guardian appointed for me, or any other person) be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. Without limiting in any way the generality of the foregoing, it is my wish that Jewish law and custom should dictate the course of my health care with respect to such matters as the performance of cardiopulmonary resuscitation if I suffer cardiac or respiratory arrest; the performance of life-sustaining surgical procedures and the initiation or maintenance of any particular course of life-sustaining medical treatment or other form of life-support maintenance, including the provision of nutrition and hydration; and the criteria by which death shall be determined, including the method by which such criteria shall be medically ascertained or confirmed.

2. **Ascertaining the Requirements of Jewish Law**: In determining the requirements of Jewish law and custom in connection with this declaration, I direct my surrogate to consult with the following Orthodox Rabbi and I ask my surrogate to follow his guidance:

Name of Rabbi: (Last) _____ (First) _____

Address: _____ Telephone: _____

If such Rabbi is unable, unwilling or unavailable to provide such consultation and guidance, then I direct my surrogate to consult with, and I ask my surrogate to follow the guidance of, an Orthodox Rabbi referred by the following Orthodox Jewish institution or organization:

Name of Institution/Organization: _____

Address: _____ Telephone: _____

If such institution or organization is unable, unwilling or unavailable to make such a reference, or if the Orthodox Rabbi referred by such institution or organization is unable, unwilling or unavailable to provide such guidance, then I direct my surrogate to consult with, and I ask my surrogate to follow the guidance of, an Orthodox Rabbi whose guidance on issues of Jewish law and custom my surrogate in good faith believes I would respect and follow.

3. **Direction to Health Care Providers**: Any health care provider shall rely upon and carry out the decisions of my surrogate, and may assume that such decisions reflect my wishes and were arrived at in accordance with the procedures set forth in this directive, unless such health care provider shall have good cause to believe that my surrogate has not acted in good faith in accordance with my wishes as expressed in this directive. If the persons designated above as my surrogate and alternate surrogate are unable, unwilling or unavailable to serve in such capacity, it is my desire, and I hereby direct, that any health care provider or other person who will be making health care decisions on my behalf follow the procedures outlined in section three (3) above in determining the requirements of Jewish law and custom. Pending contact with the surrogate and/or Orthodox Rabbi described above, it is my desire, and I hereby direct, that all health care providers undertake all essential emergency and/or life sustaining measures on my behalf.

4. **Access to Medical Records and Information; HIPAA**: I direct that all of my protected health information (as such term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) and other medical records shall be made available to my surrogate upon request in the same manner as such information and records would be released and disclosed to me, and my surrogate shall have and may exercise all of the rights I would have regarding the use and disclosure of such information and records. In the event that the authority of my surrogate has not yet been established, I authorize each of my health care providers to release and disclose all my protected health information and other medical records to the individual nominated hereunder as my surrogate for the purpose of determining my capacity to make my own health care decisions, including, without limitation, the issuance and release of any written opinion relating to my capacity that such person may have requested. The foregoing direction and authorization shall supersede any prior agreement that I may have made with any of my health care providers to restrict access to or disclosure of my protected health information or other medical records, and shall expire with respect to any health care provider upon being revoked by me in a writing delivered to such health care provider.

5. **Post-Mortem Decisions**: It is also my desire, and I hereby direct, that after my death, all decisions concerning the handling and disposition of my body be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. For example, Jewish law generally requires expeditious burial and imposes special

requirements with regard to the preparation of the body for burial. It is my wish that Jewish law and custom be followed with respect to these matters. Further, subject to certain limited exceptions, Jewish law prohibits the performance of any autopsy or dissection. It is my wish that Jewish law and custom be followed with respect to such procedures, and with respect to all other post -mortem matters including the removal and usage of any of my body organs or tissue for transplantation or any other purposes. I direct that any health care provider in attendance at my death notify the surrogate and/or Orthodox Rabbi described above immediately upon my death, in addition to any other person whose consent by law must be solicited and obtained, prior to the use of any part of my body as an anatomical gift, so that appropriate decisions and arrangements can be made in accordance with my wishes. Pending such notification, and unless there is specific authorization by the Orthodox Rabbi consulted in accordance with the procedures outlined in section three (3) above, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

6. **Incontrovertible Evidence of My Wishes**: If, for any reason, this document is deemed not legally effective as a health care proxy, or if the persons designated in section one (1) above as my surrogate and alternate surrogate are unable, unwilling or unavailable to serve in such capacity, I declare to my family, my doctor and anyone else whom it may concern that the wishes I have expressed herein with regard to compliance with Jewish law and custom should be treated as incontrovertible evidence of my intent and desire with respect to all health care measures and post-mortem procedures; and that it is my wish that the procedure outlined in section three (3) above should be followed in determining the requirements of Jewish law and custom.

DESIGNATION OF ALTERNATE AGENT

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved, annulled, or declared void unless this document provides otherwise.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:IFNOTBLANK(MedicalPOA2)

1. First Alternate Agent

Name: **FIELD(FIELD(MedicalPOA2))**

Contact Information: FIELD(AddressFIELD(MedicalPOA2))IFNOTBLANK(CityStateZip FIELD(MedicalPOA2)), FIELD(CityStateZipFIELD(MedicalPOA2)), ENDIF FIELD(PhoneFIELD(MedicalPOA2))ENDIF IFNOTBLANK(MedicalPOA3)

2. Second Alternate Agent

Name: **FIELD(FIELD(MedicalPOA3))**

Contact Information: FIELD(AddressFIELD(MedicalPOA3))IFNOTBLANK(CityStateZip FIELD(MedicalPOA3)), FIELD(CityStateZipFIELD(MedicalPOA3)), ENDIF FIELD(PhoneFIELD(MedicalPOA3))ENDIF IFNOTBLANK(MedicalPOA4)

3. Third Alternate Agent

Name: **FIELD(FIELD(MedicalPOA4))**

Contact Information: FIELD(AddressFIELD(MedicalPOA4))IFNOTBLANK(CityStateZip FIELD(MedicalPOA4)), FIELD(CityStateZipFIELD(MedicalPOA4)), ENDIF FIELD(PhoneFIELD(MedicalPOA4))ENDIF ENDIF

The original of this document is kept at FIELD(AddressP), FIELD(CityStateZipP). The following individuals or institutions have copies of the signed instrument: IF(FIELD(Subcontract))

___.ELSE Michael A. Koenecke, Attorney, P.O. Box 830190, Richardson, Texas 75083-0190, (972) 387-2904.ENDIF

DURATION

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

This power of attorney ends on the following date: EXISTS INDEFINITELY.

PRIOR DESIGNATIONS REVOKED

I revoke any prior medical durable power of attorney.

DISCLOSURE STATEMENT

THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance

with your wishes, including your religious and moral beliefs, when you are unable to make the decisions for yourself. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have if you were able to make health care decisions for yourself.

It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing facility, or residential care facility, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not allow a person to serve as both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions that you intend to have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to make those decisions, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider

orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void.

This document may not be changed or modified. If you want to make changes in this document, you must execute a new medical power of attorney.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. If you designate an alternate agent, the alternate agent has the same authority as the agent to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

(1) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR

(2) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

(1) the person you have designated as your agent;

(2) a person related to you by blood or marriage;

(3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;

(4) your attending physician;

(5) an employee of your attending physician;

(6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or

(7) a person who, at the time this medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that I have read and understand the information contained in the above disclosure statement.

IF(VARIABLE(vOneStep))ELSE EMBEDMACRO(MergeFileType (Form!) PowerBarShow (On!))ENDIF I sign my name to this medical durable power of attorney on this the IF(VARIABLE(vOneStep))VARIABLE(vDay)VARIABLE(vOrdinal) day of VARIABLE(vMonth), VARIABLE(vYear)ELSE MRGCMND(VARIABLE(vDay)VARIABLE(vOrdinal) day of VARIABLE(vMonth), VARIABLE(vYear))ENDIF , at IF(VARIABLE(vOneStep))VARIABLE(vCounty) ELSE MRGCMND(VARIABLE(vCounty))ENDIF County, Texas.

FIELD(P)

STATE OF TEXAS §
§
COUNTY OF IF(VARIABLE(vOneStep))TOUPPER(VARIABLE(vCounty))ELSE MRGCMND(TOUPPER(VARIABLE(vCounty)))ENDIF §

BEFORE ME, THE UNDERSIGNED AUTHORITY, on this day personally appeared FIELD(P), who stated that IF("TOUPPER(SUBSTR(FIELD(Sex);1;1))"="M")heELSE sheENDIF signed the above document for the purposes and considerations therein expressed.

SIGNED on this the IF(VARIABLE(vOneStep))VARIABLE(vDay)VARIABLE(vOrdinal) day of VARIABLE(vMonth), VARIABLE(vYear)ELSE MRGCMND(VARIABLE(vDay)VARIABLE(vOrdinal) day of VARIABLE(vMonth), VARIABLE(vYear))ENDIF .

Notary Public, State of Texas