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DURABLE POWER OF ATTORNEY FOR HEALTH CARE
NOTICE TO PERSON EXECUTING THIS DOCUMENT

BK 95 PG 85
W.E. DAVIS CH. CLK.

This is an important legal document. Before executing this document you should know these important facts.

This document gives the person you designate as the attorney in fact (your agent) the power to make health care decisions for you. This power exists only as those health care decisions to which you are unable to give informed consent. The attorney in fact must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep alive.

Notwithstanding this document, you have the right to make medical and other health care decisions 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 any health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any statement of your desires and limitations that you include in this document. You may state in this document any types of treatment that you do not desire to have. In addition, a court can take away the power of your agent to make health care decisions for you if your agent, (1) authorizes anything that is illegal, (2) acts contrary to your desires as stated in this document, or (3) where your desires are not known, does anything that is clearly contrary to your best interests.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital or other health care provider in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to (1) authorize an autopsy, (2) donated your body or parts thereof for transplant or for therapeutic, educational or scientific purposes, and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

This power of attorney will not be valid for making health care decisions unless it is either (a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature or (b) acknowledged before a notary public in the state.

I certify that I have read the above notice.

Morgan B. McGee

Morgan B. McGee
Dated:_____

STATE OF Mississippi
COUNTY OF DeSoto

On this 8 day of July, 2002, before me, a Notary Public in and for said state and county, duly commissioned and qualified, personally appeared **Morgan B. McGee,** to me known to be the person described in and who executes the foregoing instrument, and acknowledged that he executed the same as his free act and deed. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and Notarial Seal at office the day and year first above written.

Notary Public
My commission expires

MISSISSIPPI STATEWIDE NOTARY PUBLIC
MY COMMISSION EXPIRES APRIL 5, 2006
BONDED THRU STEGALL NOTARY SERVICE

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. DESIGNATION OF HEALTH CARE AGENT.

I, **Morgan B. McGee,** of DeSoto County, Mississippi, hereby appoint the following persons my Attorney-in-fact, to make health care decisions for me as authorized in this document:

Attorney in fact or agent: Jonathan Allen McGee
Address: 7611 Alexander's Crossing
Olive Branch, Mississippi 38654

Should Jonathan Allen McGee be unwilling or unable to act I appoint as an alternate Attorney-in fact, to make health care decisions for me as authorized in this document:

Alternate Attorney-in-fact: _____
Address: _____
_____

2. EFFECTIVE DATE AND DURABILITY.

By this document I intend to create a durable power of attorney pursuant to the Mississippi Durable Power of Attorney for Health Care Act, Mississippi Code 1972 Annotated Sections 41-41-151 through 41-41-183. The powers granted herein to my Agent **shall be effective upon my incapacity or mental infirmity.**

I desire that my wishes as expressed herein be carried out through the authority given to my Agent by this document despite any contrary feelings, beliefs or opinions of members of my family, relatives, friends, conservator or guardian.

3. AGENT'S POWERS.

I grant to my Agent full authority to make decisions for me regarding my health care. In exercising this authority, my Agent shall follow my desires as stated in this document or otherwise known to my Agent. In making any decision, my Agent shall attempt to discuss proposed decision with me to determine my desires if I am able to communicate in any way. If my Agent cannot determine the choice I would want made, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interests. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below. Accordingly, unless specifically limited by Section 4, below, my Agent are authorized as follows:

A. To consent, refuse or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation, and to consent to writing of a "No Code" or "Do Not Resuscitate" order;

B. To have access to medical records and information, verbal or written, to the same extent that I am entitled to, including the right to disclose the contents to others;

C. To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living or similar facility or service;

D. To contract on my behalf for any health care related service or facility on my behalf, without my Agent incurring personal financial liability for such contracts;

E. To hire or fire medical, social service, and other support personnel responsible for my care;

F. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death;

G. To authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law;

H. To take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, physician, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my Agent, or to seek actual or punitive damages for the failure to comply; and

I. To make advance arrangements for my funeral and burial, including the purchase of a burial plot and marker, and such other related arrangements as my Agent shall deem appropriate, if I have not already done so myself.

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.

A. The powers granted above do not include the following powers or are subject to the following rules or limitations:

_____

_____

_____

B. Organ Donor Certification.

If as indicated below I have expressed my desire to donate my organs and/or tissues for transplantation, or any of them as specifically designated herein, I do direct my attending physician, if I have been determined dead, to maintain me on artificial support systems only

for the period of time required to maintain the viability of and to remove such organs and/or tissues. **By checking the appropriate line below I specifically:**

____ desire to donate my organs and/or tissues for transplantation.

___ desire to donate my _____

_____

_____

(insert specific organs and/or tissues for transplantation)

___ DO NOT desire to donate my organs or tissues for transplantation. This certification is executed in accordance with the Mississippi Anatomical Gift Law, Mississippi Code 1972 Annotated Sections 41-39-31 through 41-39-51.

5. PROTECTION OF THIRD PARTIES WHO RELY ON MY AGENT.

No person who relies in good faith upon any representations by my Agent or any one or more of the attorneys named in paragraph 1 above shall be liable to my, my estate, my heirs or assigns, for recognizing the Agent's authority.

6. NOMINATION OF GUARDIAN.

If a guardian or conservator of myself should for any reason be appointed, I nominate _____ to act in that capacity.

Address: _____

_____

Telephone Number: _____

7. ADMINISTRATIVE PROVISIONS.

A. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

B. My Agent shall not be entitled to compensation for services performed under this power of attorney, but he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this power of attorney.

C. The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect the others.

D. Words in the singular in this document, including Agent, shall include the plural, and words in the masculine gender shall include the feminine, and vice versa.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on this 8th day of July, 2002.

My current home address is: _____

_____

Morgan B. McGee

STATE OF Mississippi
COUNTY OF DeSoto

On this 8 day of July, 2002, before me, a Notary Public in and for said state and county, duly commissioned and qualified, personally appeared Morgan B. McGee, to me known to be the person described in and who executes the foregoing instrument, and acknowledged that he/she executed the same as his/her free act and deed. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and Notarial Seal at office the day and year first above written.

Notary Public
My commission expires: April 9, 2006

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PREPARED BY & RETURN TO:
AUSTIN LAW FIRM, P.A.
ATTORNEYS AT LAW
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