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DESOTO COUNTY, MS
W.E. DAVIS, CH CLERK

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

WARNING TO PERSON EXECUTING THIS DOCUMENT

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

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.

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 you alive.

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 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 limitations that you include in this document. you may state in this document any types of treatment that you do not desire. 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; or (2) acts contrary to your desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or 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) donate your body or parts thereof for transplant or therapeutic or educational or scientific purpose; and (3) direct the disposition of your remains.

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

I sign below to evidence that I have read and understand the above warning.

Jack Rowell Sr.

JACK ROWELL, SR.

1. **DESIGNATION OF ATTORNEY-IN-FACT FOR HEALTH CARE.**

I, **JACK ROWELL, SR.**, hereby appoint **MILDRED ROWELL,** as my attorney-in-fact (my "Agent") to make health care and other decisions for me as authorized in this document.

2. **STATEMENT OF INTENT AND EFFECTIVE DATE.**

By this document I intend to create a durable power of attorney for health care in accordance with and pursuant to Section 41-41-163 of the Mississippi Code of 1972 (the "Act"). This durable power of attorney shall only become effective upon, and only remain effective during, any period of incapacity in which, in the opinion of my Agent and attending physician, I am unable to make or communicate a choice regarding a particular health care decision.

(4)

Return to:
Jack Rowell
148 Forked Cr Pkwy
Hdn 38632

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 the 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 and to make health care decisions for me is intended to be as broad as possible. Accordingly, my Agent is authorized as follows:

A. To consent or 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, artificial respiration, nutritional support and hydration and cardiopulmonary resuscitation, to the extent permitted by law at such time;

B. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose all such information 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 and fire medical, hospice, social service and other support personnel responsible for my care;

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

G. To make anatomical gifts of part or all of my body for medical purposes; to authorize an autopsy; and to direct the disposition of my remains; all to the extent permitted by applicable law at my death;

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.

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

A. With respect to any life-sustaining treatment, I do not want my life to be prolonged and I do not want life-sustaining treatment to be provided or continued if my Agent believes the burdens of the treatment outweigh the expected benefits. I want my Agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment. For the benefit of my Agent in making such decisions on my behalf, I wish to make it clear that, without limiting the foregoing authority, I do not want my life to be prolonged and I do not want life-sustaining treatment to be provided or continued:

(i) if I have a condition that is incurable or irreversible and, without the administration of life-sustaining treatment, is expected to result in death within a relatively short period of time; or

(ii) if I am in a comatose or persistent vegetative state which is reasonably concluded to be irreversible.

B. With respect to nutrition and hydration provided by means of a nasogastric tube or tube into my stomach, intestines or veins, I wish to make clear that I intend to include these procedures among the "life-sustaining procedures" that may be withheld or withdrawn under the authority given or circumstances provided above. (I realize that at the present time the Act does not permit the "withholding of simple nourishment or fluids so as to condone death by starvation or dehydration," but I nevertheless express my wishes in the hope that my Agent shall be able to carry them out, and shall be protected from any liability for seeing that my wishes are carried out.)

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

No person who relies in good faith upon any representations by my Agent shall be liable to me, my estate, my heirs or my assigns for recognizing the Agent's authority.

6. **NOMINATION OF CONSERVATOR OR LIMITED GUARDIAN.**

If the appointment of a conservator or limited guardian of my person should for any reason be necessary, I nominate my Agent to serve in such capacity.

7. **ADMINISTRATIVE PROVISIONS.**

A. If no person designated to serve as Agent is able or willing to serve or to continue to serve as such Agent, then I request that all desires I have stated in this document be honored and be given the same effect as any other written expression of intent under applicable law.

B. I hereby revoke any prior power of attorney for health care executed by me. I also hereby amend any prior general power of attorney executed by me prior to the date hereof to delete any provisions granting the attorney-in-fact in such document any power or authority I give to my Agent hereunder; provided, however, that the remaining provisions of such general power of attorney unrelated to health care shall not be affected by my signing this document.

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

D. My agent shall not be entitled to compensation for services performed under this power of attorney, but shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions of this power of attorney.

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

F. This document is not intended to, nor should it be deemed to, supersede or revoke any statutory living will executed by me pursuant to applicable law of any other state or by my subsequent execution of any such document.

G. This power of attorney shall not be revoked by any subsequent disability of incapacity of mine if such should occur. It is my express intent that the authority herein conferred upon my Agent shall be exercisable in all events upon and during and notwithstanding my subsequent disability or incapacity.

H. All references to "my Agent" in this document shall include my original attorney-in-fact named in Section 1 as well as any person who succeeds to such position.

I. I hereby grant to my Agent all of the powers provided in Sections 41-41-101 and 41-41-121 of the Mississippi Code of 1972.

CERTIFICATION

I certify that I have read the warning attached to this document, that the provisions of this document have been explained to me to my satisfaction, that I understand such provisions and that such provisions state my wishes and desires under the circumstances described.

IN WITNESS WHEREOF, I have executed this Durable Power of Attorney For Health Care on this the ____ day of July, 1996.

Jack Rowell Sr.
JACK ROWELL, SR.

I declare under penalty of perjury under the laws of Tennessee that the person who signed or acknowledged this document is personally known to me to be the principal, 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 health care provider, an employee of a health care provider, the operator of a health care institution nor an employee of an operator of a health care institution. I further declare under penalty of perjury under the laws of Tennessee 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.

Venita Hawk
WITNESS

I declare under penalty of perjury under the laws of Tennessee that the person who signed or acknowledged this document is personally known to me to be the principal, 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 health care provider, an employee of a health care provider, the operator of a health care institution nor an employee of an operator of a health care institution. I further declare under penalty of perjury under the laws of Tennessee 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.

SUSAN J. N. GARNER
WITNESS

STATE OF TENNESSEE
COUNTY OF SHELBY

On this 26 day of July, 1996, before me, Allen C Dunstan, personally appeared **JACK ROWELL, SR.**, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. 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.

Notary Public

My Commission Expires:
2/23/2000

ALLEN C. DUNSTAN
NOTARY PUBLIC AT LARGE
My Commission Expires February 23, 2000
SHELBY COUNTY, TENNESSEE

G:\USERS\LYNDA\WILLS\ROWELL\JACKSR.DPA

Prepared by
Allen Dunstan
6060 Poplar Ave
Suite 140
Memphis, Tn. 38119
Phone 901-761-1263