

### Instructions for Mr. Michael Alexander McCann for Completion of Medical Power of Attorney & Healthcare Directive

You have the right to give instructions about the management of your personal affairs and about your own health care. You also have the right to name someone else to make general decisions regarding the management of your property and to make health-care decisions for you while you are incapacitated. This document lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician.

**Part (1)** of this document is a power of attorney. It lets you name another individual as agent (also called your "attorney in fact" or "personal representative") to manage your personal affairs and make health-care decisions for you if you become incapable of making your own decisions. You may name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

Unless you limit the authority of your agent, your agent may manage your personal affairs and make health-care decisions for you while you are ill and incapacitated. Normally, one does not wish to limit the authority of one's agent. This document has a place for you to limit the authority of your agent regarding your health care. Under the laws of the State of Mississippi, if you choose not to limit the authority of your agent, your agent will have the right to:

- (A) Manage your personal affairs and take any action that you, yourself could take, including, but not limited to such things as paying your mortgage, car note and other bills while you are incapacitated, depositing and withdrawing funds from your checking or savings accounts, managing your real estate and taking care of your personal property, etc. Unless you wish for the general power of attorney to remain in effect, when and if you regain your capacity and ability to make decisions for yourself, you should revoke the general power of attorney in writing, filing the revocation at your county courthouse.
- (B) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- (C) Select or discharge health-care providers and institutions;
- (D) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- (E) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

**Part (2)** of this document is the Advance Health-Care Directive with instructions for health care which lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

**Part (3)** of this document lets you designate a physician to have primary responsibility for your health care. Designation of a physician is optional. If you have a trusted or regular family physician or doctor whom you see regularly, you may wish to designate that physician as your "primary physician" for purposes of this instrument. If you do not have a regular or family doctor, you may not wish to designate a primary physician.

**Part (4)** authorizes your doctor, hospital, clinic or other health-care providers to release protected health information to your agent.

**CHECKLIST:** After your have reviewed this document:

- \_\_\_\_\_ Call the Framme Law Firm of Mississippi, P.C., at 1-800-640-0940 if you have any questions
- \_\_\_\_\_ Talk to the person you have named as agent or personal representative to make sure that he or she understands your wishes and is willing to take the responsibility;
- \_\_\_\_\_ Complete the document, make your choices and initial each page at the bottom;
- \_\_\_\_\_ Sign in the presence of a Notary Public;
- \_\_\_\_\_ Give a copy of the signed and completed document to your agent(s), your physician, to any other health-care providers you may have, or to any health-care institution at which you are receiving care;
- \_\_\_\_\_ Take this document to your county courthouse and have it recorded.

**IMPORTANT:** You have the right to revoke this Power of Attorney for Health Care & Advance Health-Care Directive at any time. If you decide to revoke this instrument, do so in writing and take the revocation to your county courthouse for filing.

Prepared By: Edward Meeks  
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Richmond, VA 23294  
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M. McCann 6/28/06

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**POWER OF ATTORNEY FOR HEALTH-CARE DECISIONS  
WITH  
ADVANCE HEALTH-CARE DIRECTIVE**

**PART 1: POWER OF ATTORNEY**

**(1) DESIGNATION OF AGENT FOR HEALTH-CARE DECISIONS:**

- (a) I, **Michael Alexander McCann**, of **Desoto** County, Mississippi, designate **Alicia McCann** as my agent (attorney in fact or personal representative) to make health-care decisions for me as set forth in Paragraph (2)(a), below, and to make general decisions for me as set forth in Paragraph (2)(b), below.
- (b) If **Alicia McCann** is not willing, able, or reasonably available to make health-care decisions for me, or if I revoke the authority of my agent, I designate **Lee Steelgrave** of 1474 Kental Drive, Memphis, TN 38119, 901-461-5589, as my first alternate agent exclusively for health-care decisions, as set forth in Paragraph (2)(a), below.
- (c) If **Alicia McCann** is not willing, able, or reasonably available to make general decisions for me, or if I revoke the authority of my agent, I designate **David Troutman** of 592 Surfside Drive, Akron, Ohio 44319 (330-644-1493) as my first alternate agent exclusively for general decisions as set forth in Paragraph (2)(b), below

**(2) AGENT'S AUTHORITY:**

- (a) **Health care decisions:** My agent is authorized to make all health-care decisions for me, in conformity with my instructions below, if any, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive. My agent is authorized to consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition. My agent is authorized to select or discharge health-care providers and institutions. My agent is authorized to approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate. My agent is authorized to direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care. This power of attorney for health-care decisions is granted pursuant to the terms of the Mississippi Uniform Health-Care Decisions Act as set forth in §§ 41-41-201, et seq., of the Mississippi Code of 1972, as amended.
- (b) **General powers while incapacitated:** My agent may take any action in my behalf in any matter, including but not limited to the authority to manage my property and all of my personal affairs if and only if I am incapacitated as provided herein, taking any action necessary to preserve, administer and protect my real or personal property, my intangible property, my business property, my benefits or my income. This separate general power of attorney is intended to remain effective only while I am incapacitated. This general power of attorney shall take effect and be exercisable despite any lapse of time from the date this instrument is executed. This general power of attorney is granted pursuant to the terms of the Mississippi Uniform Durable Power of Attorney Act as set forth in §§ 87-3-101, et seq., of the Mississippi Code of 1972, as amended.

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**(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:**

My agent's or alternate agent's authority shall become effective immediately upon my execution of this document.

**(4) AGENT'S OBLIGATION REGARDING HEALTH-CARE DECISIONS:**

My agent shall make health-care decisions for me when I become incapacitated and in accordance with this power of attorney for health care, any instructions I give in Part 2 of this document, and my other wishes to the extent known to my agent, but only in the event that I become incapacitated and unable to make health-care decisions myself. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

**(5) NOMINATION OF GUARDIAN OR CONSERVATOR:**

If a guardian or conservator of my person or estate must be appointed pursuant to any protective proceedings in court, I nominate my agent to serve in that capacity. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agent(s) whom I have named, in the order designated.

**PART 2: ADVANCE HEALTH-CARE DIRECTIVE  
& INSTRUCTIONS FOR HEALTH CARE**

**(1) END-OF-LIFE DECISIONS:**

I direct that my agent and my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with my choice not to prolong life. I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits.

**(2) ARTIFICIAL NUTRITION AND HYDRATION:**

Artificial nutrition and hydration may be provided regardless of my condition and regardless of the choice I have made in Paragraph (1) of Part 2, immediately above.

**(3) RELIEF FROM PAIN:**

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

**(4) OTHER WISHES:**

It is my wish that my agent have the flexibility to decide whether to provide or withdraw nutrition and hydration, as my condition warrants.

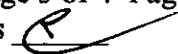
**(5) VALIDITY OF COPIES:** A copy of this document has the same effect as the original.

**PART 3: PRIMARY PHYSICIAN**

I have not designated a primary physician.

**PART 4: HIPAA AUTHORIZATION TO RELEASE  
PROTECTED HEALTH INFORMATION**

- (1) **Intent:** I intend that my agent shall have the very same access to my protected health-care information as I would have. I intend to comply, now and in the future, with all requirements set forth in the Standards for Privacy of Individually Identifiable Health Information, know as the "Privacy Rule" which implements the privacy requirement of the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320 and 45 CFR 164.510, commonly know as "HIPAA," so that the information described below will be freely available to my agent and the other individuals described below. All provisions hereof shall be construed in accordance with that intent.
- (2) **Understanding as to effect of release and re-disclosure:** I authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that if the individual or agent authorized to receive this information is not a covered entity under federal privacy regulations, the release of such information may no longer be protected by federal privacy regulations. I also understand that once this information is used or disclosed pursuant to this authorization it may be subject to re-disclosure by the recipient(s) and may no longer be protected.
- (3) **Persons or entities who may release information:** Any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and any health-care clearinghouse that has provided treatment or services to me.
- (4) **Persons to whom information may be released:** My agent or agents named herein or any Guardian or Conservator I have designated herein. My agent shall be considered my personal representative for purposes of this HIPAA release.
- (5) **Description of the information that may be used or disclosed:** Any medical records medical histories, billing records, laboratory test results, treatment notes and

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histories or any other such related information and all other individually identifiable health information about me, whether or not contained in my medical records, regarding any past or present medical or mental condition.

- (6) **Purpose(s) for the use and/or disclosure of the information:** To enable my agent to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive and to enable my agent to present my medical information to other physicians or health-care providers to aid in making those decisions.
- (7) **Revocation:** I understand that I may revoke this authorization at any time by a written document signed by me. I also understand that in the event I do revoke this authorization, it will not have any effect on the actions taken by my agent prior to receipt of the revocation or action taken in reliance on this authorization.
- (8) **Effect:** It is my intent that this authority supersedes any prior information-restricting agreements I may have made with any physician or health-care provider in the past.
- (9) **Expiration:** The release given herein has no expiration date and shall expire only in the event that I revoke this release and deliver it to my physician or health-care provider.
- (10) **Validity of copies:** A copy or facsimile of this original shall be accepted as though it was an original document.

My signature:

Michael Alexander McCann

Michael Alexander McCann

7/27/06

Date

**ACKNOWLEDGEMENT**

State of Oklahoma

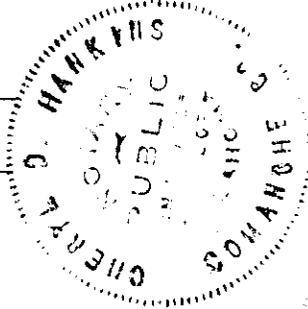
County of Comanche

On this the 27 day of July, in the year 2006, **Michael Alexander McCann** appeared before me, the undersigned Notary Public. **Michael Alexander McCann** is personally known to me (or his identity was proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this Power of Attorney for Health-Care Decisions with Advance Health-Care Directive. **Michael Alexander McCann**, upon being duly sworn, acknowledged that he signed, executed and delivered this document and further stated under oath that he did so willingly, under no constraint or undue influence, having done so on the day and in the year herein stated. I declare under the penalty of perjury that the person whose name is subscribed to this document appears to be of sound mind and under no duress or undue influence.

Cheyl D. Hankins

Notary Public 03001043

My commission expires: 1-17-07



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