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BK 124 PG 295
DESOTO COUNTY, MS
W.E. DAVIS, CH CLERK

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

PART 1: POWER OF ATTORNEY

(1) DESIGNATION OF AGENT:

- (a) I, **Jeffrey Alan Meixsell**, of **Desoto** County, Mississippi, designate **Nicole Lynn Meixsell** as my agent (attorney in fact or personal representative) to make general and health-care decisions for me.
- (b) If my agent is not willing, able, or reasonably available to make general and health-care decisions for me, or if I revoke the authority of my agent, I designate **Carl Meixsell** as my first alternate agent.

(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:** This general power shall take effect only in the event that I am determined to be incapacitated as provided Paragraph (3.), immediately below. My agent shall have full power to do all things in my name and stead concerning any and all matters in which I have an interest, except as provided herein or limited herein by my instructions regarding health-care decisions. Otherwise, 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; however, this general power of attorney shall take effect only when I am determined to be incapacitated, as provided herein. 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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Richmond, VA 23294

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Nicole Meixsell
2865 College Rd
Southaven 38672
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(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:

My agent's authority becomes effective only when my primary physician, or my treating physician, if I have not designated a primary physician, determines that I am unable to make my own health-care decisions and so informs my agent, in writing.

(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 the choice I have marked below:

(a) 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, or

(b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(2) ARTIFICIAL NUTRITION AND HYDRATION:

Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in Paragraph (1) of Part 2, immediately above, unless I mark the following box.

If I mark this box [], artificial nutrition and hydration must 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:

I direct that:

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

PART 3: PRIMARY PHYSICIAN

(1) (Optional) I designate the following physician as my primary physician:

(Name of physician)

Office Street Address, City, State and Zip Code

(2) (Optional) If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

(Name of physician)

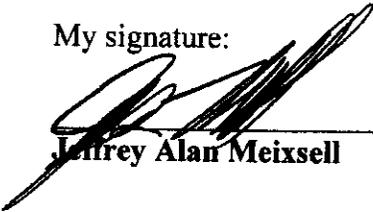
Office Street Address, City, State and Zip Code

**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 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:



 Jeffrey Alan Meixsell

1-11-07

 Date

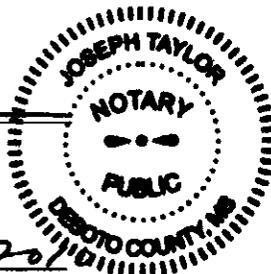
ACKNOWLEDGEMENT

State of Mississippi
 County of DeSoto

On this the 11th day of January, in the year 2007, **Jeffrey Alan Meixsell** appeared before me, the undersigned Notary Public. **Jeffrey Alan Meixsell** 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. **Jeffrey Alan Meixsell**, 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.



 Notary Public



My commission expires: 06/25/2011