

**ADVANCE HEALTH-CARE DIRECTIVE
EVA BERNICE PHILLIPS**

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. 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 the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- (b) Select or discharge health-care providers and institutions;
- (c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
- (d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form 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 form lets you designate a physician to have primary responsibility for your health care.

Part 4 of this form lets you authorize the donation of your organs at your death, and declares that this decision will supersede any decision by a member of your family.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

**PART I
POWER OF ATTORNEY FOR HEALTH CARE**

1. **DESIGNATION OF AGENT.** I designate the following individual as my agent to make health-care decisions for me:

Edward Glenn Phillips

(name of agent)

1801 S. Horne Street, Oceanside, CA 92054

(address)

760-439-5478 (home) 760-685-7262 (cell)

(phone numbers)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

Kelly Blake Phillips

(name of first alternate agent)

9529 Waterwood Court, Raleigh, NC 27614

(address)

919-720-4273 (home) 919-524-7850 (work)

(phone numbers)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

Chris Marie Maglior

(name of second alternate agent)

1559 Ivy, Hernando, MS 38632

(address)

662-449-1686 (home) 901-490-2272 (cell)

(phone numbers)

2. **AGENT'S AUTHORITY:** My agent is authorized 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, except as I state here:

(Add additional sheets if needed.)

HIPAA Authorization: My agent(s) named above shall have the status, power, authority and rights as my Personal Representative(s) for all purposes as provided in the Health Insurance Portability and Accountability Act of 1996, (Pub. L. 104-191), 45 CFR Section 160 through 164 (HIPAA). All provisions under this Section shall be effective immediately for all purposes and shall continue to be effective until three years after my death.

I direct each health care provider or Covered Entity to release to my agent any and all such of my protected health information as may be requested by my agent and deemed necessary by my agent in order for my agent to perform their respective duties and/or for my agent to make any decision authorized hereunder, immediately or in the future. I authorize my agent to execute any and all releases and other documents necessary in order to obtain disclosure to my agent of my patient records and other protected health information that may be subject to and protected under the Health Insurance Portability and Accountability Act.

3. **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE.** My agent's authority becomes effective when my primary physician, or any physician in consultation with my health care provider, determines that I am unable to make my own health-care decisions, unless I mark or initial the statement below:

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[] I want my agent's authority to make health care decisions for me effective immediately.

4. **AGENT'S OBLIGATION:** My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. 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:** If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2 INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do not fill out this part of the form, you may strike any wording you do not want.

6. **END-OF-LIFE DECISIONS:** I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

Ebp [] (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

Ebp [] (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.~~

7. **ARTIFICIAL NUTRITION AND HYDRATION:** Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) 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 (6).

8. **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: _____

9. **OTHER WISHES:** (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

Ebp I do not wish to have my life prolonged.

(Add additional sheets if needed.)

**PART 3
PRIMARY PHYSICIAN (OPTIONAL)**

10. I designate the following physician as my primary physician:

Dr. Troy Morris

(name of physician)

75 Physician Lane, Southaven, MS 38671

(address)

(city)

(state)

(zip code)

662-393-7722

(phone)

**PART 4
CERTIFICATE OF AUTHORIZATION FOR ORGAN DONATION (OPTIONAL)**

Ebp

I, the undersigned, this _____ day of _____, 2011, desire that my organ(s) be made available after my demise for:

(a) Any licensed hospital, surgeon or physician, for medical education, research, advancement of medical science, therapy or transplantation to individuals;

(b) Any accredited medical school, college or university engaged in medical education or research, for therapy, educational research or medical science purposes or any accredited school of mortuary science;

(c) Any person operating a bank or storage facility for blood, arteries, eyes, pituitaries, or other human parts, for use in medical education, research, therapy or transplantation to individuals;

(d) The donee specified below, for therapy or transplantation needed by him or her, do donate my _____ for that purpose to
(name) _____ at
(address) _____

I authorize a licensed physician or surgeon to remove and preserve for use my _____ for that purpose.

I specifically provide that this declaration shall supersede and take precedence over any decision by my family to the contrary.

Witnessed this _____ day of _____, 2011.

(date)

(donor signature)

11. **EFFECT OF COPY:** A copy of this form has the same effect as the original.

**PART 5
OTHER PROVISIONS**

12. **CAPACITY:** Unless otherwise provided in this document, this document does not affect my right to make Health-Care Decisions while I have the capacity to do so. I shall be presumed to have capacity to make a Health-Care Decision, to give or revoke an Advance Health-Care Directive, and to designate or disqualify a Surrogate.

13. **EFFECT OF MY OBJECTIONS:** Nothing in this document authorizes my Agent to consent to Health Care, or to consent to the withholding or withdrawal of Health Care

necessary to keep me alive, if I object to the Health Care or to the withholding or withdrawal of the Health Care.

14. **EMERGENCY CARE:** This health-care directive does not affect the law governing Health Care treatment in an emergency.

15. **PHYSICAL REMAINS:** My Agent may make the following decisions for me, before or after my death, to the same extent as I could make Health Care Decisions for myself if I had the capacity to do so:

- (a) making a disposition under the State's Anatomical Gift Act;
- (b) authorizing an autopsy; and/or
- (c) directing the disposition of my remains.

~~16. **MENTAL HEALTH INSTITUTION:** This document authorizes the Agent to consent to my admission to a mental health-care institution unless my written advance health-care directive expressly provides otherwise.~~

17. **MEDICAL RECORDS:** My Agent has the same right as me to receive and review medical records, and to consent to the disclosure of medical records when acting pursuant to this health-care power of attorney, and shall be considered my personal representative (as well as my health care representative) for health care disclosures under federal HIPAA regulations.

18. **AUTOMATIC REVOCATION OF SPOUSE:** A decree of annulment, divorce, dissolution of marriage or legal separation revokes any designation of my spouse as my Agent.

19. **REVOCATION:** This document shall be effective until revoked by me. In any event, any revocation or amendment may, but is not required to, be filed in the records of the Chancery Clerk of the county in which I reside.

(a) At any time while I have the capacity, I may either (i) revoke the appointment of my Agent under this document by notifying my Agent in writing, or (ii) revoke the authority granted to my Agent to make Health Care decisions by notifying the Health Care Provider in writing or by personally informing the supervising Health Care Provider.

(b) If I notify the Health Care Provider in writing that the authority granted to my Agent to make Health Care Decisions is revoked, the Health Care Provider shall make the notification a part of my medical records.

(c) This health-care directive revokes any prior Durable Power of Attorney for Health Care that I have made in the past, except that powers granted by me on matters other than health care shall continue in full force and effect.

(d) If authority granted by this health-care directive is revoked under this section, a person is not subject to criminal prosecution or civil liability for acting in good faith reliance upon this power of attorney unless the person has actual knowledge of the revocation.

(e) A Health Care Provider is not subject to criminal prosecution, civil liability or professional disciplinary action if the Health Care Provider relies on a Health Care Decision and both of the following requirements are satisfied: (i) the decision is made by an Agent who the Health Care Provider believes in good faith is authorized to make the decision, and (ii) the Health Care Provider believes in good faith that the decision is not inconsistent with my desires

as expressed in this health-care directive or otherwise made known to the Health Care Provider, and, if the decision is to withhold or withdraw health care necessary to keep me alive, the Health Care Provider has made a good faith effort to determine my desires to the extent I am able to convey these desires to the Health Care Provider, and the results of the effort are made a part of my medical records.

(f) Notwithstanding the Health Care Decision of my Agent, the Health Care Provider is not subject to criminal prosecution, civil liability or professional disciplinary action for failing to withdraw Health Care necessary to keep me alive.

20. **SUCCESSOR AGENT:** If my Agent desires to resign as my Agent and there is no successor Agent named in this instrument who is willing and able to serve as my Agent, then upon such resignation my Agent is authorized and empowered to appoint a substitute agent to act and serve as my Agent, such appointment to be made in a written instrument that shall be (a) signed by my Agent, (b) delivered to my substitute Agent, and (c) attached to this instrument.

21. **FINANCIAL POWER OF ATTORNEY:** In the event a decision of my Agent will need the expenditure of my resources and I have appointed another agent under a power of attorney with control over my general finances, or I have otherwise given financial control to another, then the person with control of my funds from which such expenditures will be made shall be required to approve the decision.

22. **RESPONSIBILITY TO MONITOR:** My Agent shall have no responsibility under this instrument to monitor on any regular basis the state of my physical health or mental competence to determine if any actions need to be taken.

23. **PARTIAL VALIDITY:** If any part of any provision of this instrument shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity only, without in any way affecting the remaining parts of such provision or the remaining provisions of this instrument.

24. **PROTECTION OF AGENT:** My Agent is not subject to criminal prosecution, civil liability or professional disciplinary action for exercising in good faith the authority granted to my Agent under this health-care directive.

25. **PHOTOCOPIES:** My Agent is authorized to make photocopies of this instrument as frequently and in such quantity as my Agent shall deem appropriate. Each photocopy shall have the same force and effect as any original.

26. **BINDING AUTHORITY:** This instrument and actions taken by my Agent properly authorized hereunder shall be binding upon me, my heirs, successors, assigns, executors, and administrators.

27. **ACTS CONNECTED WITH AUTHORIZATION:** In connection with the exercise of the powers herein described, my Agent is fully authorized and empowered to perform any acts and things and to execute and deliver any documents, instruments, and papers necessary, appropriate, incident, or convenient to such exercise or exercises, including without limitation the following:

(a) to seek on my behalf and at my expense: (i) a declaratory judgment from any court of competent jurisdiction interpreting the validity of this instrument and any of the acts authorized by this instrument, but such declaratory judgment shall not be necessary in order for

my Agent to perform any act authorized by this instrument, (ii) a mandatory injunction requiring compliance with my Agent's instructions by any person, organization, corporation, or other entity obligated to comply with instructions given by me, and/or (iii) actual and punitive damages against any person, organization, corporation, or other entity obligated to comply with instructions given by me who negligently or willfully fails or refuses to follow such instructions;

(b) to employ and discharge medical personnel including, but not limited to, physicians, psychiatrists, dentists, nurses, and therapists as my Agent shall deem necessary for my physical, mental, and emotional well-being, and to authorize reasonable compensation;

(c) to give or withhold consent to any medical procedures, tests, or treatments, including surgery; to arrange for my hospitalization, convalescent care, hospice, or home care; and under circumstances in which my Agent determines that certain medical procedures, tests, or treatments are no longer of any benefit to me or where the benefits are outweighed by the burdens imposed, to revoke, withdraw, modify, or change consent to such procedures, tests, and treatments, as well as hospitalization, convalescent care, hospice, or home care which I or my Agent may have previously allowed or consented to. My Agent's decision should be guided by taking into account (i) the provisions of this document, (ii) any reliable evidence of preferences that I may have expressed on the subject, whether before or after the execution of this document, (iii) what my Agent believes I would want done in the circumstances if I were able to express myself, and (iv) any information given to my Agent by the physicians treating me as to my medical diagnosis and prognosis and the intrusiveness, pain risks, and side effects of the treatment;

(d) to take whatever steps are necessary or advisable to enable me to remain in my personal residence as long as it is reasonable under the circumstances. I realize that my health may deteriorate so that it may become necessary to have round-the-clock nursing care if I am to remain in my personal residence, and I direct my agent to obtain such care (including any equipment that might assist in that care) as is reasonable under the circumstances. Specifically, I do not want to be hospitalized or put in a convalescent or similar home as long as it is reasonable to maintain me in my personal residence;

(e) to exercise my right of privacy and my right to make decisions regarding my medical treatment even though the exercise of my rights might hasten my death or be against conventional medical advice;

(f) to consent to and arrange for the administration of pain-relieving drugs of any kind, or other surgical or medical procedures calculated to relieve my pain, including unconventional pain-relief therapies which my Agent believes may be helpful to me, even though such drugs or procedures may lead to permanent physical damage, addiction, or even hasten the moment of my death; and

(g) to grant, in conjunction with any instructions, given under this health-care directive, releases to hospital staff, physicians, nurses, and other medical and hospital administrative personnel who act in reliance on instructions given by my Agent or who render written opinions to my Agent in connection with any matter described in this Article from all liability from damages suffered or to be suffered by me; to sign documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice" as well as any necessary waivers of or releases from liability required by any hospital or physician to implement my wishes regarding medical treatment or non-treatment.

28. **PETITION OF COURT:** The Agent may petition any court of competent jurisdiction to enjoin or direct a health-care decision or order other equitable relief.

29. **GOVERNING LAW:** This instrument shall be governed by the laws of the State of Mississippi in all respects, including its validity, construction, interpretation, and termination. I intend for this health-care power of attorney to be honored in any jurisdiction when it may be presented and given the most liberal interpretation available for purposes of granting my Agent the fullest amount of discretion in making decisions on my behalf. I also intend that any such jurisdiction refer to the laws of the state referred to above to interpret and determine the validity of this document and any of the powers granted hereunder. Should any physician or Health Care Institution fail to honor this health-care directive, then my Agent is authorized to terminate the services of such persons and institutions and to transfer my care to another physician or Health Care Institution that will honor the instructions of my Agent.

PART 6 DEFINITIONS

For purposes of this document, the following words when capitalized in the document shall have the meaning ascribed in this section unless the context shall otherwise require:

(a) "Agent" means an individual designated in this health-care directive to make a health-care decision for me, the person granting the power.

(b) "Capacity" means my ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a Health-Care Decision.

(c) "Health Care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect my physical or mental condition.

(d) "Health-Care Decision" means a decision made by me or my Agent, Guardian or Surrogate, regarding the individual's health care, including: (i) selection and discharge of Health-Care Providers and Institutions; (ii) approval or disapproval of diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and (iii) directions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of Health Care.

The phrase "Health-Care Decision" does not include decisions made pursuant to Sections 41-39-31 through 41-39-51, the "Anatomical Gift Law."

(e) "Health-Care Institution" means an institution, facility, or agency licensed, certified, or otherwise authorized or permitted by law to provide Health Care in the ordinary course of business.

(f) "Health-Care Provider" means an individual licensed, certified, or otherwise authorized or permitted by law to provide Health Care in the ordinary course of business or practice of a profession.

30. **SIGNATURES:** Sign and date the form here:

10-20-11

(date)

Eva Bernice Phillips

(sign your name)

EVA BERNICE PHILLIPS

31. WITNESSES: 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.

(NOTARY ACKNOWLEDGEMENT)

STATE OF MISSISSIPPI

COUNTY OF DeSoto

On this 20th day of October, in the year 2011, before me, W.E. Davis Chancery Clerk by Janet Knight (insert name of notary public) appeared Eva Bernice Phillips (name of client), 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 the 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.

W.E. Davis Chancery Clerk
NOTARY PUBLIC
By: Janet Knight

My Commission Expires:

My Commission Expires January 2, 2012

Prepared by:
Richard A. Courtney, ~~PLLC~~
Frascogna Courtney, PLLC
4400 Old Canton Road, Suite 220
Jackson, Ms. 39211
601-987-3000



Return to:
* Bernice Phillips
7211 Brenwood Dr.
Horn Lake, Ms. 38637

ALTERNATIVE NO. 2

(WITNESS ACKNOWLEDGEMENTS)

Witness

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. 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.

(date)	(signature of witness)
(address)	(printed name of witness)
(city) (state)	

Witness

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this 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 agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

(date)	(signature of witness)
(address)	(printed name of witness)
(city) (state)	