

This Instrument Prepared by:
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(901) 474-1222

**ADVANCE HEALTH-CARE DIRECTIVE AND
DURABLE POWER OF ATTORNEY FOR HEALTH CARE FOR
MARGIE MAE FRAZIER**

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. This designation is, however, optional.

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. 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 including, but not limited to, 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.

Part 3 of this form lets you designate, if you so desire, a physician to have primary responsibility for your health care.

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After completing this form, sign and date the form at the end and have the form witnessed. You may desire to 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 and power of attorney for health care form or replace this form at any time.

PART 1 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:

Deborah Ann Graham

(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.

(3) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my primary treating physician determines that I am unable to make my own health-care decisions.

(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 agent whom I have named in this document.

PART 2 INSTRUCTIONS FOR HEALTH CARE

(6) **END-OF-LIFE DECISIONS:** 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.

(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 (7).

(8) **RELIEF FROM PAIN:** I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

(9) **OTHER WISHES:** I direct that my agent has the power and authority:

- a. To consent, refuse to consent, 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;
- b. To request, review, and receive any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records; to execute on my behalf any releases or other documents that may be required in order to obtain this information; and to consent to the disclosure of this information;
- 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's incurring personal financial liability for such contracts;
- e. To employ and discharge medical, social service, and other support personnel responsible for my care;
- f. To authorize, or refuse to authorize, or withdraw authorization for, 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 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, including seeking actual and punitive damages for the failure to comply;

- h. **HIPAA Release Authority:** I intend by this power of attorney to designate the individual or individuals who shall have authority to act on my behalf in making decisions related to my health care. In exercising such authority, my agent shall constitute my "personal representative" (as defined in 45 CFR § 164.502(g)(1)) and be treated as I would be for all purposes of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC § 1320d and 45 CFR §§ 160 and 164, and as such shall (1) have access to all my "individually identifiable health information," including any "protected health information" (as those terms are defined in the regulations under HIPAA at 45 CFR § 160.103), verbal or written; (2) possess, without limitation, my right of access to inspect and obtain a copy of protected health information about me as required by HIPAA at 45 CFR §164.524; and (3) possess, without limitation, my right to an accounting of disclosures of protected health information as required by HIPAA at 45 CFR § 164.528. I authorize 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, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition. The authority given my agent herein shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. My agent's exercise of the powers under this paragraph shall not be deemed events: (1) in which treating my agent as my personal representative could endanger me for purposes of 45 CFR § 164.502(g)(5)(i)(B); or (2) in which it is not in my best interest for my agent to be treated as my personal representative for purposes of 45 CFR § 164.502(g)(5)(ii). This authority applies to any information governed by HIPAA and may not be revoked unless I revoke the authority in writing and deliver it to my health-care provider. **NOTWITHSTANDING ANY OTHER PROVISIONS OF THIS INSTRUMENT, THIS HIPAA AUTHORITY SHALL BE EFFECTIVE UPON EXECUTION OF THIS POWER OF ATTORNEY AND SHALL NOT BE AFFECTED BY MY SUBSEQUENT DISABILITY OR INCAPACITY.**

**PART 3
PRIMARY PHYSICIAN**

(10) **DESIGNATION OF PRIMARY PHYSICIAN:** I do not wish to designate a physician as my primary physician responsible for my health care.

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

(12) PROTECTION OF THIRD PARTIES WHO RELY ON MY AGENT: No person who relies in good faith upon my representations by my agent or any alternate agent shall be liable to my estate or my heirs or assigns for recognizing the agent's authority.

(13) ADMINISTRATIVE PROVISIONS:

- a. I revoke any prior power of attorney for health care executed by me and not previously revoked by me.
- b. This power of attorney for health care is intended to be valid in any jurisdiction in which it is presented.
- c. My agent shall not be entitled to compensation for services performed under this power of attorney for health care, 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 for health care.
- d. The powers delegated under this power of attorney for health care are separable, so that the invalidity of one or more powers shall not affect any others.

(14) SIGNATURE: Sign and date the form here:

Dated this 24th day of February, 2012.


MARGIE MAE FRAZIER

(16) WITNESSES: This power of attorney for healthcare will not be valid for making health-care decisions unless it acknowledged before a notary public in the state of Mississippi.

STATE OF MISSISSIPPI

COUNTY OF DESOTO

On this 24th day of February, in the year 2012, before me, Sandra Edwards (notary's name), appeared **MARGIE MAE FRAZIER**, 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 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.

Sandra Edwards
NOTARY PUBLIC

My Commission Expires:

8-3-14
[Notary Seal]



Return To:

Deborah GRAHAM
3906 Homewood Rd
Memphis, TN 38118
(901) 366-1546