

of deterioration, dependence, and hopeless pain. I, therefore, ask that drugs and medication be mercifully administered to me to alleviate suffering even though this may hasten the moment of death.

I realize that when life-sustaining treatment is withheld or withdrawn from me, I will surely die of dehydration and malnutrition within days or weeks. I direct that all available medication for the relief of pain and for my comfort shall be administered to me after life-sustaining treatment is withheld or withdrawn even if I am rendered unconscious and my life is shortened thereby. I do not draw a distinction between nutrition and hydration and any other kind of life-sustaining treatment, and I expressly authorize my agent to direct that nutrition and hydration be withdrawn or withheld from me when my agent believes it is in my best interest to do so.

I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company and the Medical Information Bureau, Inc., or other 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 individual identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

The authority given to my agent 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.

In addition to the other powers granted by this document, I grant to my agent the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and its regulations (HIPAA) during any time that my agent (hereinafter referred to as my "HIPPA personal representative") is exercising authority under this document.

Pursuant to HIPPA, I specifically authorize my HIPPA personal representative to request, receive and review any information regarding my physical or mental health, including, without limitation, all HIPPA-protected health information, medical and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required in order to obtain this information and to consent to the disclosure of this information. I further authorize my HIPPA personal representative to

execute on my behalf any documents necessary or desirable to implement the health care decisions that my HIPPA personal representative is authorized to make under this document.

By signing this document, I specifically empower and authorize my physician, hospital or health care provider to release any and all medical records to my HIPPA personal representative or to my representative's designee. Release of such information to such representative or representative's designee prior to the empowerment of such representative under this proxy is authorized if requested by such representative or representative's designee for purposes of determining whether I can no longer take part in decisions as to what is best for my future, viz that this health care proxy has become effective.

The authority given to my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider. This proxy shall not be affected by my subsequent disability or incompetency.

This proxy is given while I am in good health and spirits, and is given with the intention of sharing responsibility for any health care decisions that are made on my behalf, and of placing responsibilities upon me for the actions taken by my agent. If no agent named herein is able to act for me, this proxy shall be viewed as a living will.

IN WITNESS WHEREOF, I have signed this Proxy this ____ day of _____, 2008.

Address: _____

This form is for informational purposes only and is not executable.