DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

NOTICE AND WARNING TO PERSON EXECUTING THIS DOCUMENT --

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE EXECUTING THIS DOCUMENT YOU SHOULD KNOW THESE IMPORTANT FACTS:

EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT (THE ATTORNEY-IN-FACT) THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU WHEN YOU ARE NO LONGER CAPABLE OF MAKING HEALTH CARE DECISIONS FOR YOURSELF. YOUR AGENT MUST ACT CONSISTENTLY WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN. UNLESS YOU STATE OTHERWISE, YOUR AGENT HAS THE SAME AUTHORITY TO MAKE DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE HAD.

YOUR AGENT HAS THE POWER TO MAKE A BROAD RANGE OF HEALTH CARE DECISIONS FOR YOU. THE PERSON YOU APPOINT AS YOUR AGENT SHOULD BE SOMEONE YOU KNOW AND TRUST. YOU SHOULD DISCUSS THIS DOCUMENT WITH YOUR AGENT.

EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER TO CONSENT TO YOUR PHYSICIAN NOT GIVING TREATMENT OR STOPPING TREATMENT NECESSARY TO KEEP YOU ALIVE.

NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION AT THE TIME, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT AT THE TIME.

THIS DOCUMENT GIVES YOUR AGENT AUTHORITY TO CONSENT, TO REFUSE TO CONSENT, OR TO WITHDRAW CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. THIS POWER IS SUBJECT TO ANY STATEMENT OF YOUR DESIRES AND ANY LIMITATIONS THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY SPECIFY IN THIS DOCUMENT ANY TYPES OF TREATMENT THAT YOU DO OR DO NOT DESIRE.

IN ADDITION, A COURT CAN TAKE AWAY THE POWER OF YOUR AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOUR AGENT AUTHORIZES ANYTHING THAT IS ILLEGAL OR ACTS CONTRARY TO YOUR KNOWN DESIRES AS STATED IN THIS DOCUMENT.

YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY OF YOUR AGENT OR TO REVOKE THIS DOCUMENT ENTIRELY BY NOTIFYING YOUR AGENT OR YOUR ATTENDING PHYSICIAN, HOSPITAL OR OTHER HEALTH CARE PROVIDER ORALLY OR IN WRITING OF THE REVOCATION.

IT IS IMPORTANT THAT YOU UNDERSTAND THE NATURE AND RANGE OF DECISIONS THAT MAY BE MADE ON YOUR BEHALF. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK YOUR ATTORNEY OR PHYSICIAN TO EXPLAIN IT TO YOU.

YOUR AGENT MAY NEED THIS DOCUMENT IMMEDIATELY IN CASE OF AN EMERGENCY THAT REQUIRES A DECISION CONCERNING YOUR HEALTH CARE. EITHER KEEP THIS DOCUMENT WHERE IT IS IMMEDIATELY AVAILABLE TO YOUR AGENT AND ALTERNATE AGENT OR GIVE EACH OF THEM AN EXECUTED COPY OF THIS DOCUMENT. YOU ALSO MAY WANT TO GIVE YOUR PHYSICIAN AN EXECUTED COPY OF THIS DOCUMENT.

TO: My family, physicians and all those concerned with my care:

I, **, presently residing at *, and being an adult of sound mind, hereby appoint and authorize my wife, **, presently residing at *, tel. no.: *, or if my wife is unable, unwilling or unavailable to act, then *, presently residing at * , tel. no.: *, as my agent and attorney-in-fact to act for me and in my name to make and communicate any and all decisions about or relating to my receipt or refusal to accept medical treatment, diagnostic procedures, surgery, hospitalization, care and treatment in a nursing home or other facility, health care, nursing care or personal care, in any situation in which, as the result of illness, disease, mental deterioration or injury, I am incapable of making or communicating a decision with respect to my treatment or care. This authorization includes the right to refuse and direct the withdrawal of medical treatment which would prolong my life, and to communicate health care decisions to all persons including without limitation my physicians, health care providers and family.

If I am determined by two doctors, one of whom is my family physician, to be in a persistent vegetative state and there is no reasonable expectation of recovery therefrom, or to be suffering from a terminal illness or condition, and am determined to be in the end stages of that illness or condition, I direct that all life-prolonging procedures be withheld or withdrawn, unless they are necessary to keep me comfortable and to relieve pain. The procedures and treatment to be withheld and withdrawn include, without limitation, surgery, antibiotics, cardiac and pulmonary resuscitation, and dialysis, chemotherapy, radiation therapy, mechanical ventilator and respiratory support. I expressly authorize the withholding and withdrawal of artificially provided food, water, and other nourishment and fluids.

I further delegate to my agent and attorney-in-fact the power and authority to select, employ and discharge health care personnel, such as physicians, nurses, therapists, hospice care and home health care providers, and other medical professionals; to admit or discharge me (including transfer from another facility) from any hospital, hospice, nursing home, adult home or other medical care facility; to apply for public benefits to defray the cost of health care; and to contract in my name and on my behalf for all health care services, including without limitation medical, nursing and hospital care, as my agent and attorney-in-fact may deem appropriate. I confirm that I shall be and remain personally liable for the payment of all such care and services to the same extent as if I had personally contracted therefor.

I wish to live out my last days at home rather than in a hospital, if it does not impose an undue burden on my family.

I grant to my agent the authority and power to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, the regulations in 45 C.F.R. Sec. 160 et seq., and any other applicable federal, state or local laws or regulations (collectively "HIPAA"), including the authority to request, receive, obtain and review, and be granted full and unlimited access to, and consent to the disclosure of complete unredacted copies of any and all health, medical and financial information and any information or records referred to in 45 C.F.R. Sec. 164.501 and regulated by the Standards for Privacy of

Individually Identifiable Health Information found in 65 Fed. Reg. 82462 as protected private records or otherwise covered under HIPAA. I understand that health and medical records can include information relating to subjects such as sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) and human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol or drug abuse or addiction. I understand that I may have access to or receive an accounting of the information to be used or disclosed as provided in 45 C.F.R. Sec. 164.524 et seq. I further understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that any disclosure of this information carries with it the potential for an unauthorized further disclosure of this information by third parties and that such further disclosure may not be protected under HIPAA. In order to induce the disclosing party to disclose the aforesaid private and/or protected confidential information, I forever release and hold harmless said disclosing party who relies upon this instrument from any liability under confidentiality rules arising under HIPAA as a consequence of said disclosure. I authorize my agent to execute any and all releases or other documents that may be necessary in order to obtain disclosure of my patient records and other medical information subject to and protected by HIPAA.

I authorize my agent and attorney-in-fact to execute on my behalf any documents necessary or desirable to implement the health care decisions that my agent and attorney-in-fact is authorized to make pursuant to this document, including without limitation all documents pertaining to a refusal to permit medical treatment, or authorizing the leaving of a medical facility against medical advice, or any waivers or releases from liability required by a physician or health care provider.

THIS DOCUMENT IS A DURABLE POWER OF ATTORNEY AND THE AUTHORITY OF MY AGENT AND ATTORNEY-IN-FACT SHALL NOT TERMINATE IF I BECOME DISABLED, INCOMPETENT OR INCAPACITATED.

The power of attorney becomes effective upon certification by two licensed physicians that I am incapacitated and can no longer communicate and/or make my own medical decisions. The powers and duties of my agent and attorney-in-fact shall cease upon certification that I am no longer incapacitated. This determination of incapacity shall be periodically reviewed by my attending physician and my agent.

If any provision of this document is held to be invalid or unenforceable, the remainder of this document shall continue in full force and effect.

IN WITNESS WHEREOF, I, **, sign this instrument this * day of *, 2010, and, being first duly sworn, do hereby declare to the undersigned authority that I execute it willingly, as my free and voluntary act and deed for the purposes therein expressed, and that I am eighteen years of age or older, of sound mind, and under no constraint, duress, fraud or undue influence.

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STATE OF MISSOURI)
) ss.
COUNTY OF ST. LOUIS)

Sworn to, acknowledged and signed by **, on this * day of *, 2010.

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David A. Rubin
Notary Public
Commissioned in St. Louis County, Missouri