POWER OF ATTORNEY:

CARE AND CUSTODY OF CHILD OR CHILDREN

{DELEGATION OF POWERS BY PARENTS(S)}

KNOW ALL MEN BY THESE PRESENTS: That, pursuant to Alabama Code 26-2A-7, I/we,_____and_____ _____,residing at_____ hereby make, constitute and appoint _____ *(if more than one attorney-in-fact is appointed, add 'Jointly," "either of them" or "any one of them" to indicate how they must act)* as our true and lawful Attorney(s)-in-Fact, to act in my/our name, place and stead, to do and execute all or any of the following acts, deeds and things with respect to the care and custody of my/our child/children:

_____

_____

(a) To participate in decisions regarding their education including attending conferences with their teachers or any other educational authorities, granting permission for their participation in school trips and other activities, and making any other decisions and executing any documents pertinent to their education.

(b) To grant permission and consent to my/our children participating in any activity sponsored by any group, association or organization which activity our Attorney(s)-in-Fact may deem appropriate.

(c) To make health care decisions on behalf of my/our children, including making decisions regarding their medical or dental care, whether routine or emergency in nature, including admissions to hospitals or other institutions; to consent to, to refuse to consent to, or to withdraw consent to the provision of any care, tests, treatment, surgery, service or procedure to maintain, diagnose or treat a physical or mental condition, as well as the right to sign such medical forms as may be necessary to carry out such decisions; to talk with health care personnel who may be treating our children and to examine their medical records and to consent to the disclosure of such records in circumstances the Attorney(s)-in-Fact may deem appropriate; to file claims for medical insurance and to obtain information from any

insurance company with respect to any policy of health or medical insurance under which our children are insured; provided however, that our Attorney(s)-in-Fact shall not be required to execute any documents which would involve incurring any personal liability for any such treatment and care, and I/we affirm that I/we will be responsible for payment for any such care or treatment consented to by our Attorney(s)-in-Fact which is not covered by insurance.

(d) To generally do and perform all matters and things, to execute all other instruments of every kind which may be necessary or proper to effectuate all powers hereinabove specifically granted, or any other matter or thing appertaining to my/our children, with the same full powers, and to all intents and purposes, with the same validity as we could, if personally present; and hereby ratifying and confirming whatsoever my/our said Attorney(s)-in-Fact shall and may do, by virtue hereto.

(e) SPECIFICALLY EXCLUDED FROM THE AUTHORITY AND POWERS GRANTED HEREIN IS THE AUTHORITY OR POWER TO CONSENT TO THE MARRIAGE OR ADOPTION OF THE CHILD(REN) NAMED HEREIN.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY CHILD'S PHYSICAL OR MENTAL HEALTH.

A. General Grant of Power and Authority. Subject to any limitations in this Directive, my agent has the power and authority to do all of the following: (1) Request, review and receive any information, verbal or written, regarding my child's physical or mental health including, but not limited to, medical and hospital records; (2) Execute on my behalf any releases or other documents that may be required in order to obtain this information; (3) Consent to the disclosure of this information; and (4) Consent to the donation of any of my child's organs for medical purposes.

B. HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my child's individually identifiable health information or other medical records. This release authority applies to any information governed by the Health

Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. 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 my child, 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 child's individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my child's health care providers to restrict access to or disclosure of my child's individually identifiable health information. The authority given 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 child's health care provider.

The powers herein granted to my/our said Attorney(s)-in-Fact shall be exercisable by any one of them or all of them at any time and from time to time, for a period not exceeding one year, from _____ until_____. We further understand that this temporary power of attorney (delegation) of our parental powers does not relieve us of the primary responsibility of our child;

This Power of Attorney shall remain in full force and effect until the date stated above, and any party dealing with my/our Attorney (s)-in-fact during such time shall be fully protected and is hereby discharged, released and indemnified from so doing in respect of any matter relating hereto unless such particular party shall have received prior notice in writing of the revocation of this Power of Attorney.

IN WITNESS WHEREOF, we hereunto set our hands and seals, this the _____day of _____, _____.

_____ (SEAL)

_____ (SEAL)

STATE OF _____

COUNTY OF _____

I, the undersigned, a Notary Public, in and for said County, in said State, hereby certify that _____and_____, whose name(s) are signed to the foregoing Power of Attorney and who is known to me, acknowledged before me on this day, that, being fully informed of the contents of the foregoing instrument, they executed the same voluntarily on the day the same bears date.

Given under my hand and official seal, this the _____ day of _____, _____.

_____

Notary Public

(NOTARIAL SEAL)

My commission expires: _____