POWER OF ATTORNEY:
CARE AND CUSTODY OF CHILD OR CHILDREN

KNOW ALL MEN BY THESE PRESENTS: That the undersigned, _____, parent(s) of the child(ren) identified below, 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 the true and lawful Attorney(s)-in-Fact of the undersigned, to act in name, place and stead of the undersigned, to do and execute all or any of the following acts, deeds and things with respect to the care and custody of the following child(ren):

_____

_____

_____

(a) To participate in decisions regarding the child(ren)'s education including attending conferences with the child(ren)'s teachers or any other educational authorities, granting permission for the child(ren)'s 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 the child(ren) participating in any activity sponsored by any group, association or organization which activity the Attorney(s)-in-Fact may deem appropriate.

(c) To make health care decisions on behalf of the child(ren), including making decisions regarding the child(ren)'s 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 the child(ren) and to examine the child(ren)'s 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 the child(ren) may be insured; provided however, that the 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 the undersigned affirms that the undersigned will be responsible for payment for any such care or treatment consented to by the Attorney(s)-in-Fact of the undersigned 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 the child(ren) of the undersigned, with the same full powers, and to all intents and purposes, with the same validity as the undersigned could, if personally present; and hereby ratifying and confirming whatsoever said Attorney (s)-in-fact of the undersigned 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 said Attorney(s)-in-Fact of the undersigned shall be exercisable by any one of them or all of them at any time and from time to time from _____ until _____ (not to exceed six months).

This Power of Attorney shall remain in full force and effect until the date stated above, and any party dealing with the 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 _____, _____.

_____
(Signature)

_____
(Optional, but preferred: Your social security number)

Dated:_____ _____, 20_____

_____
(Signature)

_____
(Optional, but preferred: Your social security number)

Dated:_____, 20_____

COUNTY OF _____, STATE OF NEW MEXICO

The foregoing instrument was acknowledged before me this _____day of _____, 20 _____, by _____.

My Commission Expires: _____

_____
Notary Public