1. HEALTH CARE POWER OF ATTORNEY

DECLARATION made this ______ day of ________________ 2005.

I, ______________________________, as principal, designate ______________________________, as my Agent ("*Agent*") for all matters relating to my health care, including without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my Agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is an uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

If ______________________________ is unable to act as my Agent for any reason, including death or disability, then I hereby make, constitute and appoint the following each to act alone and successively, in the order named as successor to my Agent:

1. First Alternate Agent: ______________________________

2. Second Alternate Agent: ______________________________

I have completed and included herein a Living Will for purposes of providing specific direction to my Agent in situations that may occur during any period when I am unable to make or communicate health care decisions or after my death. My Agent is directed to implement those choices I have initialed in the Living Will.

I willfully and voluntarily authorize my Agent to receive information in my health care records and exchange information with any of my health care providers, including, but not limited to, all Protected Health Information (as defined under the Health Insurance Portability and Accountability Act "HIPAA," to include all individually identifiable health information), information regarding my health history; any diagnosis, treatment or prognosis I have or have had, even if such includes information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV); behavioral or mental health services, or treatment for alcohol and drug abuse. I understand that once the above information is disclosed, it may be re-disclosed by my Agent and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of this information identified is voluntary.

As of this date, I have not completed a Prehospital Medical Directive pursuant to Section 36-3251, Arizona Revised Statutes. However, I reserve the right to do so in the future.

This Health Care Directive is made under Section 36-3221, Arizona Revised Statutes, and continues in effect for all who may rely on it except those to whom I have given notice of its revocation.

The addresses and telephone numbers of my Agent and Alternate Agent are attached hereto and incorporated herein by this reference.

2. MENTAL HEALTH

I give my Agent the power to make decisions for my mental health care treatment that are consistent with my wishes as expressed in this document or, if not specifically expressed, as are otherwise known to my Agent.

If my wishes are unknown to my Agent, I want my Agent to make decisions regarding my mental health care that are consistent with what my Agent in good faith believes to be in my best interests. My Agent is also authorized to receive information regarding proposed mental health treatment and to receive, review and consent to disclosure of any medical records relating to that treatment.

This declaration allows me to state my wishes regarding mental health care treatment including medications, admission to and retention in a health care facility for mental health treatment and outpatient services.

The following are my wishes regarding my mental health care treatment if I become incapable, as defined in Section 36-3281, Arizona Revised Statutes.

________ (a) I expressly consent to give my Agent the power to admit me to an inpatient or partial psychiatric hospitalization program.

________ (b) I expressly consent to give my Agent the power to consent to medical treatment against my wishes only pursuant to the development of a specific treatment plan that is reviewed and approved by a physician.

This Mental Health Care Power of Attorney is made pursuant to Title 36, Chapter 32, Article 6, Arizona Revised Statutes, and continues in effect for all who may rely on it except to those I have given notice of its revocation pursuant to Section 36-3285.

3. LIVING WILL

(Some general statements concerning your health care options are outlined below. If you agree with one of the statements, you should initial that statement. READ ALL OF THESE STATEMENTS CAREFULLY BEFORE YOU INITIAL YOUR SELECTION. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs 1, 2, and 3 but if you initial paragraph 4, the others should not be initialed.)

________ 1. If I have a terminal condition, I do not want my life to be prolonged and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.

________ 2. If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I do not want the following:

___________ (a) Cardiopulmonary resuscitation, for example, the use of drugs, electric shock and artificial breathing.

___________ (b) Artificially administered food and fluids.

___________ (c) To be taken to a hospital if at all avoidable unless an excessive burden is placed on those individuals providing my care.

________ 3. Notwithstanding my other directions, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

________ 4. I want my life to be prolonged to the greatest extent possible.

Other or additional statements or desires

I have _________ I have not ___________ attached additional special provisions or limitations to this document to be honored in the absence of my being able to give health care directions.

SIGNED: ___________________________________

____

____

CITY COUNTY STATE

STATE OF ARIZONA)
) ss.
County of _________)

The foregoing Health Care Power of Attorney and Living Will was executed in my presence this ______ day of ________________ 2005, by _________________________, who appeared to be of sound mind and free from duress at the time of execution. I further state that I am not the agent appointed herein, nor am I directly involved with providing health care to the principal. Furthermore, I am not related to the principal by blood, marriage, or adoption nor am I entitled to any part of the principal's estate by Will or by operation of law.

____

Notary Public