MyDirectives®

Summary for Physicians

Printed January 23, 2018 1:18 PM CDT

Important Note to readers of this document:
To verify that this document is the most current version available for Roger Rienman McBee, please click here, or go to https://qa.mydirectives.com/verify and enter this ID: **aeea122** and this check sum: **Wge2EgB0Ko**, or scan the QR code on the left.

ROGER RIENMAN MCBEE

Version 11 signed on 11/8/2016 10:43 AM CDT.
See uADD™ and Signing Certificate for details.

Version 10 signed on 7/19/2014 5:45 PM CDT
Version 9 signed on 7/19/2014 9:05 AM CDT

For more information, see MyDirectives.com.

Patient Information

McBee, Roger Rienman

456 Vaultina Dr.
Dallas, TX 75219

(214) 585-9878
(214) 533-8525
rogerb@testaccount.edu

Gender: Male
DOB: 4/1/1945

Healthcare Providers

Dr. Warren LIttle *(Hematologist-Oncologist)*
(469) 238-2858
jdsmith@advaultinc.com

Dr. Allen Park *(General Practitioner)*
4547858887
skennedy@advaultinc.com

Insurance

Health Insurance
Anthem Blue Cross and Blue Shield
Phone: (844) 565-9874
Policy No.: 4567-A58-PZ345
Group No.: G8
Policy Holder: Roger McBee

Disability Insurance
AARP Medicare Supplement
Phone: (800) 568-5874
Policy No.: RP-345-101-8765
Group No.: AA345
Policy Holder: Roger McBee

Healthcare Agent

Jeff Zucker *(Friend)*
zuckerjeff@gmail.com
[As of 1/23/2018,
at 1:18 PM CDT, a response is still PENDING]

Powers:
I've read the list of powers normally given to healthcare agents and agree to grant them.

Current Medical Condition

My doctor tells me I may die soon.

POLST On File:
Yes

Treatment Goals

Most Important To You:
1. Being at peace with my God
2. Being with my family
3. Being free from pain
4. Not being a physical burden to my family
5. Being able to feed, bathe, and take care of myself
6. Resolving conflicts

Document Override:
- *No, If I am declared incompetent, follow this document.*

Religion, Faith, or Spirituality:
- *I don't want my doctors and nurses to know about the role religion, faith, or spirituality play in my life.*

Palliative Care:
- *Yes, please contact palliative care team.*

Preferences

If I'm Terminally Ill:
- *I would like them to keep trying life-sustaining treatments indefinitely.*

If I Have a Severe, Irreversible Brain Injury or Illness and Cannot Communicate or Perform Basic Self-Help:
- *I would like them to keep trying life-sustaining treatments for 2 months.*

Cardiopulmonary Resuscitation (CPR)
I understand that this is not a physician order, so medical personnel may not be able to honor my wishes, but here are my thoughts on CPR:
- *I want CPR attempted unless my doctor says I have a terminal illness or a severe, irreversible brain injury, OR I have little chance of long-term survival if my heart or breathing stop, and an attempt to resuscitate me would cause me significant suffering, OR it simply will not work in my condition.*

Final Preferences

Final Days:
- *At home. I want hospice care at home if possible.*

Organ Donation:
- *I want to donate Heart, Kidneys, Eyes to help save someone else's life.*

Autopsy:
- *I want an autopsy if my doctor thinks it will help others.*

My Thoughts

My likes / joys:
Like Bach, especially the cantatas. St. Martin in the Fields.

How to care for me:
I don't like being treated like an object. I would like to be greeted like a person before working on me.

My religion:
- *Not Religious*

My unfinished business:
I am awaiting a message from the Nobel Prize Committee. Please keep me alive if I look promising this year.

If I were to pass away:
I have a plot. My wife has the details, also my secretary, Ms. Williams, will know.

Alternate Healthcare Agents

First Alternate:
S. Leonard Susskind
(Friend)
sbrown@advaultinc.com
[ACCEPTED to act as a healthcare agent on 11/8/2016, at 3:37 PM CDT]

Second Alternate:
Jay Z Polkinghorne
(friend)
jzucker@advaultinc.com
[ACCEPTED to act as a healthcare agent on 2/14/2012, at 12:47 PM CDT]

Personal Contacts

Jay Z Polkinghorne
(friend)
jzucker@advaultinc.com

Jeff Zucker
(Friend)
zuckerjeff@gmail.com

S. Leonard Susskind
(Friend)
sbrown@advaultinc.com

Attention Healthcare Providers: MyDirectives® recommends you review this Summary and the uADD™ with this person to reconfirm this information is still current. Then for your security, please ask the person to sign and date below in your presence.

Roger Rienman McBee Date

Witness (optional) Date

Universal Advance Digital Directive (uADD™)

Roger Rienman McBee

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It is very important for you to discuss your medical treatment goals and wishes with your healthcare agent, your family, and your medical care providers. Keep in mind that advance medical directives are simply expressions of your medical treatment goals and preferences. There is no guarantee that your medical care providers will follow all of your wishes, but one thing is certain: **If your advance medical directives cannot be quickly located and retrieved in a time of need, then medical care providers, your family and friends will not be able to take your wishes into consideration when they make critical decisions regarding your treatment.**

Part 1

Appointment of a Primary Healthcare Agent and Alternate Healthcare Agents

IF THIS PART OF THE uADD™ IS LEFT BLANK, I AM DELIBERATELY DECLINING TO DESIGNATE A HEALTHCARE AGENT AND REQUESTING THAT THE DOCTORS ON DUTY MAKE DECISIONS BASED ON MY GUIDELINES.

I am appointing the person or persons below as my healthcare agent and, if applicable, as my alternate healthcare agent(s), and I am granting to each of them the legal authority to make medical treatment decisions on my behalf and to consult with my physician and others. The power to make medical treatment decisions that I am granting to my healthcare agent(s) is expressly subject to, and limited by, the choices that I have expressed elsewhere in my uADD. If my medical treatment choices are not clear, I am authorizing and directing my healthcare agent to make decisions in my best interests and based on what is known of my wishes.

The person I choose as my Primary Healthcare Agent is:

Jeff Zucker (Friend)
zuckerjeff@gmail.com
[As of 1/23/2018, at 1:18 PM CDT, a response is still PENDING]

If this healthcare agent is unable or unwilling to make medical treatment decisions for me, or if my spouse is designated as my primary healthcare agent and our marriage is annulled, or we are divorced or legally separated, **then my next choice for a healthcare agent is:**

First Alternate Healthcare Agent

S. Leonard Susskind (Friend)
sbrown@advaultinc.com
[ACCEPTED to act as a healthcare agent on 11/8/2016, at 3:37 PM CDT]

Roger Rienman McBee

Part 1 *cont.*

If this alternate healthcare agent is unable or unwilling to make medical treatment decisions for me, or if my spouse is designated as my first alternate healthcare agent and our marriage is annulled, or we are divorced or legally separated, **then my next choice for a healthcare agent is:**

Second Alternate Healthcare Agent

Jay Z Polkinghorne (friend)

jzucker@advaultinc.com

[ACCEPTED to act as a healthcare agent on 2/14/2012, at 12:47 PM CDT]

My Healthcare Agent's General Authority

Subject to my medical treatment choices expressed elsewhere in this uADD™ and applicable law that requires otherwise, *I grant to my healthcare agent the power to make all choices and medical treatment decisions for me.*

Roger Rienman McBee

Part 2

Expression of Healthcare Treatment Wishes and Desires

If I cannot express my own wishes for medical treatment, I would like the doctors treating me, as well as my healthcare agent if I have chosen one, to make decisions based as much as possible and appropriate on my instructions below. *If at some point in the future I am declared incompetent, I DO NOT want to be allowed to override these preferences. I want my doctors to follow the preferences I express in this document.*

My Advance Care Goals

If I am so sick or seriously injured that I cannot express my own medical treatment preferences, and if I am not expected to live without additional treatment for my illness, disease, condition or injury, then I want my medical care team to know that these are the things that are most important to me:

1. Being at peace with my God

2. Being with my family

3. Being free from pain

4. Not being a physical burden to my family

5. Being able to feed, bathe, and take care of myself

6. Resolving conflicts

If I am having significant pain or suffering, I would like my doctors to consult a Supportive and Palliative Care Team to help treat my physical, emotional and spiritual discomfort, and to support my family.

My Preferences in Specific Circumstances

In addition to the general advance care goals provided above, below are specific treatment preferences with respect to certain specific circumstances or situations.

If my health ever deteriorates due to a terminal illness, and my doctors believe I will not be able to interact meaningfully with my family, friends, or surroundings, *I would like for them to keep trying life-sustaining treatments indefinitely.*

If I have a severe, irreversible brain injury or illness and can't dress, feed, or bathe myself, or communicate my medical wishes, but doctors can keep me alive in this condition for a long period of time, *I would like for them to keep trying life-sustaining treatments for 2 months.*

Although I understand that, depending on the situation and circumstances, medical personnel may not be able to follow my wishes, here are my general thoughts on cardiopulmonary resuscitation (CPR):

Roger Rienman McBee

Part 2 *cont.*

I want CPR attempted unless my doctor says I have a terminal illness or a severe, irreversible brain injury, OR I have little chance of long-term survival if my heart or breathing stop, and an attempt to resuscitate me would cause me significant suffering, OR it simply will not work in my condition.

Other Instructions

If it were possible to choose, here is where I would like to spend my final days:

At home. I would like to receive hospice care at home if possible.

Unless I have stated otherwise somewhere else in this uADD™, I understand that my healthcare agent may reconsider my medical treatment choices expressed above in light of my other instructions contained elsewhere in this uADD™ or new medical information.

Roger Rienman McBee

Part 3 Decisions on Organ Donation and Autopsy

Consent to Donate

I consent to donate the following organs and tissues: Heart, Kidneys, Eyes.

Autopsy

I want an autopsy if my doctor thinks it will help others.

Roger Rienman McBee

Part 4 My Thoughts

MyDirectives® offers people a list of optional questions that can be answered by typing text in a text box or by uploading a video or audio file for each question. Only those questions answered by Roger Rienman McBee appear here. For a complete list of questions in My Thoughts, please visit www.MyDirectives.com.

In case I'm being cared for by a person(s) who doesn't know me very well, I'd like my following thoughts to be known.

My likes / joys: Here are some examples of the things that I would like to have near me, music that I'd like to hear, and other details of my care that would help to keep me happy and relaxed:

Like Bach, especially the cantatas. St. Martin in the Fields.

How to care for me: If I become incapacitated and cannot express myself, here is what I would like to tell my healthcare agent, family and friends about how I would like for them to care for me:

I don't like being treated like an object. I would like to be greeted like a person before working on me.

My religion: If I appear to be approaching the end of my life, here are some things that I would like for my caregivers to know about my faith and my religion.Please attempt to notify someone from the *Not Religious* religion at the following phone number, if I have included one.

My unfinished business: If it appears that I am approaching the end of my life, and I cannot communicate with persons around me, I would want my doctors and nurses, my family, and my friends to know about some unfinished business that I need to address:

I am awaiting a message from the Nobel Prize Committee. Please keep me alive if I look promising this year.

If I were to pass away: Here are my thoughts on funeral or burial plans:

I have a plot. My wife has the details, also my secretary, Ms. Williams, will know.

Roger Rienman McBee

Part 5

Making the uADD™ Legal

I am emotionally and mentally competent to make this uADD. I understand the purpose and effect of this uADD, I agree with everything that is written in this uADD, and I have made this uADD knowingly, willingly and after careful deliberation.

Roger McBee — 11/8/2016

Signature (or my signature signed by the person named below) — Date

Statement of Witnesses

I declare that the person who signed this uADD, or who asked another to sign this uADD on his/her behalf, is the individual identified in the document, and he/she did so in my presence or otherwise provided satisfactory proof to me of his/her identity. I believe him/her to be of sound mind and at least 18 years of age. I personally witnessed him/her sign this document or ask the person indicated to do so, or I received proof of his/her identity that I believe is adequate, and I believe that he/she did so voluntarily. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not related to the person signing this document by blood, marriage or adoption.
- Not a healthcare agent appointed by the person signing this document.
- Not directly financially responsible for that person's healthcare.
- Not a healthcare provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain), officer, director, or partner of a healthcare provider (or any parent organization of such healthcare provider) directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

Witness Number 1:

Signature — Date

Witness Number 2:

Signature — Date

Roger Rienman McBee

Part 5 *cont.*

Instructions for Notarization:

Residents of certain jurisdictions are required to have the uADD signed by a notary public registered in their jurisdiction, in addition to having witnesses sign the uADD. Other jurisdictions allow the uADD to be signed by a notary public without requiring witnesses.

Notary Public

In my presence on _____ (date), _____ (name) acknowledged his/her signature on this uADD or acknowledged that he/she authorized the person signing this uADD to sign on his/her behalf. I am not named as a healthcare agent or alternate healthcare agent in this document.

Signature of Notary _____

My commission expires on _____ (date)

MyDirectives®

Special Notices and Information Regarding Healthcare Agents and Advance Directives

Roger Rienman McBee

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In the 21st century, we know people can create a document in one place, technically live or reside in another place, and have a medical emergency while in yet another place. MyDirectives believes the individual's voice, values, goals and preferences for medical treatment need to be heard no matter where the person is when they create or need their advance care plan and advance directives. That being said, certain places in the world have laws that require that we provide you with special notices and information. The information provided directly below covers almost every place in the world, with the exception of three states in the United States (Ohio, Oregon and Wisconsin). If you normally spend more than six months a year in any of these states, please look at the specific notices for these states at the bottom of this document to see whether one of these notices might apply to you. When you sign your Universal Advance Digital Directive (uADD)™, you are also acknowledging that you have read and understood any such notice.

Your Universal Advance Digital Directive ("uADD")™ is an important document. Before you sign it, you should know these important facts:

Unless you state otherwise, the section of your uADD entitled, "Part 1 – Appointment of a Primary Healthcare Agent and Alternate Healthcare Agents," gives the person you name as your healthcare agent the authority to make all healthcare decisions for you in accordance with your wishes, when your doctor certifies that you lack the capacity to make healthcare decisions. Because "healthcare" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition, your healthcare agent has the power to make a broad range of healthcare decisions for you. Your healthcare agent may be able to consent, refuse to consent, or withdraw consent to medical treatment, and may make decisions about withdrawing or withholding various life-sustaining treatments. Also, your agent may or may not be able to consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery or abortion. Finally, in some places in the world, a doctor must comply with your agent's instructions or allow you to be transferred to another doctor.

Your healthcare agent's authority usually begins when a doctor certifies that you lack the capacity to make or communicate healthcare decisions. If for moral or religious reasons you do not want to be treated by a doctor or to be examined by a doctor to certify that you lack capacity, some places in the world have laws that require you to say so in your advance directives. They may also require you to name someone who can certify your lack of capacity. In most cases, your healthcare agent is required to follow your instructions when making decisions on your behalf. Also, in most places, unless you state otherwise, your healthcare agent has the same authority to make decisions about your healthcare as you would have had.

MyDirectives® provides a wide choice of tools to help you make educated, informed decisions about your treatment preferences and who you should choose to make decisions for you if needed. Authorities in some jurisdictions still believe it is important that you discuss your uADD with your doctor or other healthcare provider before you sign it to be sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a doctor, you should talk with someone who knows about these issues and can answer your questions. You do not need a lawyer's assistance to complete your uADD, but if there is anything in your

uADD that you do not understand, some authorities believe you should ask a lawyer's advice.

Here are some recommendations on who you should (and should not) choose to be your healthcare agent: the person you appoint as your healthcare agent should be someone you know and trust; he or she should be at least 18 years old, or be a person under 18 that has been granted adult status by a court order. If you appoint your health or residential care provider (e.g., your doctor or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative) to be your healthcare agent, the laws of many jurisdictions will require that person to choose between acting as your healthcare agent or as your health or residential care provider. Many laws do not permit a person to do both at the same time.

You should inform the person you appoint that you want him or her to be your healthcare agent. MyDirectives gives you tools that help you to contact your chosen healthcare agent and alternate healthcare agents, to have discussions with them about your medical treatment wishes, and to share your uADD™ with your healthcare agents and your doctors. Your healthcare agent is not liable for healthcare decisions made in good faith on your behalf.

Even after you have signed your uADD, you have the right to change and update it at any time. You also have the right to make healthcare decisions for yourself as long as you are able to do so. In most places, treatment cannot be given to you or stopped over your objection. You also have the right to revoke the authority granted to your healthcare agent by informing your agent or your health or residential care provider verbally or in writing, by signing a subsequent medical power of attorney, or by updating your uADD at any time. In many places, unless you state otherwise, your appointment of a spouse as your healthcare agent automatically cancels if you divorce.

In most cases, making changes to your uADD will require you to resign it and get new witness or notary signatures as required by the laws of the place where you live. We encourage you to use MyDirectives to add a video or audio signature to your uADD, as well. Once you have created and signed a new uADD, it will automatically revoke any previous uADD you have created.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make healthcare decisions for you. MyDirectives allows you to designate up to two alternate healthcare agents. We also allow you to flag people in your circle of contacts that you would like for doctors to talk to, even if they are not your officially designated healthcare agent.

Your uADD may not be not valid unless it is signed by witnesses or notaries as required by the laws of the place where you live or where you are being treated. IT IS YOUR RESPONSIBILITY TO KNOW WHAT THE SIGNATURE REQUIREMENTS ARE IN YOUR JURISDICTION, AS APPLICABLE.

The following are examples of persons designated by many laws as not being able to act as one of the witnesses: the person you have designated as your healthcare agent; a person related to you by blood or marriage; a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law; your attending physician; an employee of your attending physician; an employee of a healthcare facility where you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the healthcare facility or of any parent organization of the healthcare facility; or a person who, at the time this uADD is executed, has a claim against any part of your estate after your death.

Special Notices and Information Regarding Healthcare Agents and Advance Directives

Roger Rienman McBee

By my signature below, I expressly acknowledge and agree that I have read and understand the information above.

Signature: *Roger McBee* Date: *11/8/2016*

Roger Rienman McBee

ADDITIONAL NOTICE TO OHIO (USA) RESIDENTS:

NOTICE TO ADULT EXECUTING THIS DOCUMENT:

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

THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE (THE ATTORNEY IN FACT) THE POWER TO MAKE MOST HEALTH CARE DECISIONS FOR YOU IF YOU LOSE THE CAPACITY TO MAKE INFORMED HEALTH CARE DECISIONS FOR YOURSELF. THIS POWER IS EFFECTIVE ONLY WHEN YOUR ATTENDING PHYSICIAN DETERMINES THAT YOU HAVE LOST THE CAPACITY TO MAKE INFORMED HEALTH CARE DECISIONS FOR YOURSELF AND, NOTWITHSTANDING THIS DOCUMENT, AS LONG AS YOU HAVE THE CAPACITY TO MAKE INFORMED HEALTH CARE DECISIONS FOR YOURSELF, YOU RETAIN THE RIGHT TO MAKE ALL MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF.

YOU MAY INCLUDE SPECIFIC LIMITATIONS IN THIS DOCUMENT ON THE AUTHORITY OF THE ATTORNEY IN FACT TO MAKE HEALTH CARE DECISIONS FOR YOU.

SUBJECT TO ANY SPECIFIC LIMITATIONS YOU INCLUDE IN THIS DOCUMENT, IF YOUR ATTENDING PHYSICIAN DETERMINES THAT YOU HAVE LOST THE CAPACITY TO MAKE AN INFORMED DECISION ON A HEALTH CARE MATTER, THE ATTORNEY IN FACT GENERALLY WILL BE AUTHORIZED BY THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU TO THE SAME EXTENT AS YOU COULD MAKE THOSE DECISIONS YOURSELF, IF YOU HAD THE CAPACITY TO DO SO. THE AUTHORITY OF THE ATTORNEY IN FACT TO MAKE HEALTH CARE DECISIONS FOR YOU GENERALLY WILL INCLUDE THE AUTHORITY TO GIVE INFORMED CONSENT, TO REFUSE TO GIVE INFORMED CONSENT, OR TO WITHDRAW INFORMED CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION.

HOWEVER , EVEN IF THE ATTORNEY IN FACT HAS GENERAL AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR YOU UNDER THIS DOCUMENT, THE ATTORNEY IN FACT NEVER WILL BE AUTHORIZED TO DO ANY OF THE FOLLOWING:

(1) REFUSE OR WITHDRAW INFORMED CONSENT TO LIFE-SUSTAINING TREATMENT (UNLESS YOUR ATTENDING PHYSICIAN AND ONE OTHER PHYSICIAN WHO EXAMINES YOU DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT EITHER OF THE FOLLOWING APPLIES:

(A) YOU ARE SUFFERING FROM AN IRREVERSIBLE, INCURABLE, AND UNTREATABLE CONDITION CAUSED BY DISEASE, ILLNESS, OR INJURY FROM WHICH (I) THERE CAN BE NO RECOVERY AND (II) YOUR DEATH IS LIKELY TO OCCUR WITHIN A RELATIVELY SHORT TIME IF LIFE-SUSTAINING TREATMENT IS NOT ADMINISTERED, AND YOUR ATTENDING PHYSICIAN ADDITIONALLY DETERMINES, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT THERE IS NO REASONABLE POSSIBILITY THAT YOU WILL REGAIN THE CAPACITY TO MAKE INFORMED HEALTH CARE DECISIONS FOR YOURSELF.

(B) YOU ARE IN A STATE OF PERMANENT UNCONSCIOUSNESS THAT IS CHARACTERIZED BY YOU BEING IRREVERSIBLY UNAWARE OF YOURSELF AND YOUR ENVIRONMENT AND BY A TOTAL LOSS OF CEREBRAL CORTICAL FUNCTIONING, RESULTING IN YOU HAVING NO CAPACITY TO EXPERIENCE PAIN OR SUFFERING, AND YOUR ATTENDING PHYSICIAN ADDITIONALLY DETERMINES, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT THERE IS NO REASONABLE POSSIBILITY THAT YOU WILL REGAIN THE CAPACITY TO MAKE INFORMED HEALTH CARE DECISIONS FOR YOURSELF);

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(2) REFUSE OR WITHDRAW INFORMED CONSENT TO HEALTH CARE NECESSARY TO PROVIDE YOU WITH COMFORT CARE (EXCEPT THAT, IF THE ATTORNEY IN FACT IS NOT PROHIBITED FROM DOING SO UNDER (4) BELOW, THE ATTORNEY IN FACT COULD REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU AS DESCRIBED UNDER (4) BELOW). **(YOU SHOULD UNDERSTAND THAT COMFORT CARE IS DEFINED IN OHIO LAW TO MEAN ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) WHEN ADMINISTERED TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH, AND ANY OTHER MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE THAT WOULD BE TAKEN TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH. CONSEQUENTLY, IF YOUR ATTENDING PHYSICIAN WERE TO DETERMINE THAT A PREVIOUSLY DESCRIBED MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN, THEN, SUBJECT TO (4) BELOW, YOUR ATTORNEY IN FACT WOULD BE AUTHORIZED TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE.)**;

(3) REFUSE OR WITHDRAW INFORMED CONSENT TO HEALTH CARE FOR YOU IF YOU ARE PREGNANT AND IF THE REFUSAL OR WITHDRAWAL WOULD TERMINATE THE PREGNANCY (UNLESS THE PREGNANCY OR HEALTH CARE WOULD POSE A SUBSTANTIAL RISK TO YOUR LIFE, OR UNLESS YOUR ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO EXAMINES YOU DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT THE FETUS WOULD NOT BE BORN ALIVE);

(4) REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) TO YOU, UNLESS:

(A) YOU ARE IN A TERMINAL CONDITION OR IN A PERMANENTLY UNCONSCIOUS STATE.

(B) YOUR ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED YOU DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN.

(C) IF, BUT ONLY IF, YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE, YOU AUTHORIZE THE ATTORNEY IN FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU BY DOING BOTH OF THE FOLLOWING IN THIS DOCUMENT:

(I) INCLUDING A STATEMENT IN CAPITAL LETTERS OR OTHER CONSPICUOUS TYPE, INCLUDING, BUT NOT LIMITED TO, A DIFFERENT FONT, BIGGER TYPE, OR BOLDFACE TYPE, THAT THE ATTORNEY IN FACT MAY REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE AND IF THE DETERMINATION THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN IS MADE, OR CHECKING OR OTHERWISE MARKING A BOX OR LINE (IF ANY) THAT IS ADJACENT TO A SIMILAR STATEMENT ON THIS DOCUMENT;

(II) PLACING YOUR INITIALS OR SIGNATURE UNDERNEATH OR ADJACENT TO THE STATEMENT, CHECK, OR OTHER MARK PREVIOUSLY DESCRIBED.

(D) YOUR ATTENDING PHYSICIAN DETERMINES, IN GOOD FAITH, THAT YOU AUTHORIZED THE ATTORNEY IN FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE BY COMPLYING WITH THE REQUIREMENTS OF (4)(C)(I) AND (II) ABOVE.

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(5) WITHDRAW INFORMED CONSENT TO ANY HEALTH CARE TO WHICH YOU PREVIOUSLY CONSENTED, UNLESS A CHANGE IN YOUR PHYSICAL CONDITION HAS SIGNIFICANTLY DECREASED THE BENEFIT OF THAT HEALTH CARE TO YOU, OR UNLESS THE HEALTH CARE IS NOT, OR IS NO LONGER, SIGNIFICANTLY EFFECTIVE IN ACHIEVING THE PURPOSES FOR WHICH YOU CONSENTED TO ITS USE.

ADDITIONALLY, WHEN EXERCISING AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR YOU, THE ATTORNEY IN FACT WILL HAVE TO ACT CONSISTENTLY WITH YOUR DESIRES OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTEREST. YOU MAY EXPRESS YOUR DESIRES TO THE ATTORNEY IN FACT BY INCLUDING THEM IN THIS DOCUMENT OR BY MAKING THEM KNOWN TO THE ATTORNEY IN FACT IN ANOTHER MANNER.

WHEN ACTING PURSUANT TO THIS DOCUMENT, THE ATTORNEY IN FACT GENERALLY WILL HAVE THE SAME RIGHTS THAT YOU HAVE TO RECEIVE INFORMATION ABOUT PROPOSED HEALTH CARE, TO REVIEW HEALTH CARE RECORDS, AND TO CONSENT TO THE DISCLOSURE OF HEALTH CARE RECORDS.

YOU CAN LIMIT THAT RIGHT IN THIS DOCUMENT IF YOU SO CHOOSE.

GENERALLY, YOU MAY DESIGNATE ANY COMPETENT ADULT AS THE ATTORNEY IN FACT UNDER THIS DOCUMENT. HOWEVER, YOU CANNOT DESIGNATE YOUR ATTENDING PHYSICIAN OR THE ADMINISTRATOR OF ANY NURSING HOME IN WHICH YOU ARE RECEIVING CARE AS THE ATTORNEY IN FACT UNDER THIS DOCUMENT. ADDITIONALLY, YOU CANNOT DESIGNATE AN EMPLOYEE OR AGENT OF YOUR ATTENDING PHYSICIAN, OR AN EMPLOYEE OR AGENT OF A HEALTH CARE FACILITY AT WHICH YOU ARE BEING TREATED, AS THE ATTORNEY IN FACT UNDER THIS DOCUMENT, UNLESS EITHER TYPE OF EMPLOYEE OR AGENT IS A COMPETENT ADULT AND RELATED TO YOU BY BLOOD, MARRIAGE, OR ADOPTION, OR UNLESS EITHER TYPE OF EMPLOYEE OR AGENT IS A COMPETENT ADULT AND YOU AND THE EMPLOYEE OR AGENT ARE MEMBERS OF THE SAME RELIGIOUS ORDER.

THIS DOCUMENT HAS NO EXPIRATION DATE UNDER OHIO LAW, BUT YOU MAY CHOOSE TO SPECIFY A DATE UPON WHICH YOUR DURABLE POWER OF ATTORNEY FOR HEALTH CARE GENERALLY WILL EXPIRE. HOWEVER, IF YOU SPECIFY AN EXPIRATION DATE AND THEN LACK THE CAPACITY TO MAKE INFORMED HEALTH CARE DECISIONS FOR YOURSELF ON THAT DATE, THE DOCUMENT AND THE POWER IT GRANTS TO YOUR ATTORNEY IN FACT WILL CONTINUE IN EFFECT UNTIL YOU REGAIN THE CAPACITY TO MAKE INFORMED HEALTH CARE DECISIONS FOR YOURSELF.

YOU HAVE THE RIGHT TO REVOKE THE DESIGNATION OF THE ATTORNEY IN FACT AND THE RIGHT TO REVOKE THIS ENTIRE DOCUMENT AT ANY TIME AND IN ANY MANNER. ANY SUCH REVOCATION GENERALLY WILL BE EFFECTIVE WHEN YOU EXPRESS YOUR INTENTION TO MAKE THE REVOCATION. HOWEVER, IF YOU MADE YOUR ATTENDING PHYSICIAN AWARE OF THIS DOCUMENT, ANY SUCH REVOCATION WILL BE EFFECTIVE ONLY WHEN YOU COMMUNICATE IT TO YOUR ATTENDING PHYSICIAN, OR WHEN A WITNESS TO THE REVOCATION OR OTHER HEALTH CARE PERSONNEL TO WHOM THE REVOCATION IS COMMUNICATED BY SUCH A WITNESS COMMUNICATE IT TO YOUR ATTENDING PHYSICIAN.

IF YOU EXECUTE THIS DOCUMENT AND CREATE A VALID DURABLE POWER OF ATTORNEY FOR HEALTH CARE WITH IT, IT WILL REVOKE ANY PRIOR, VALID DURABLE POWER OF ATTORNEY FOR HEALTH CARE THAT YOU CREATED, UNLESS YOU INDICATE OTHERWISE IN THIS DOCUMENT.

THIS DOCUMENT IS NOT VALID AS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE UNLESS IT IS ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR IS SIGNED BY AT LEAST TWO ADULT WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. NO PERSON WHO IS RELATED TO YOU BY BLOOD, MARRIAGE, OR ADOPTION MAY BE A WITNESS. THE ATTORNEY IN FACT, YOUR ATTENDING PHYSICIAN, AND THE ADMINISTRATOR OF ANY NURSING HOME IN WHICH YOU ARE RECEIVING CARE ALSO ARE INELIGIBLE

Roger Rienman McBee

TO BE WITNESSES.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK YOUR LAWYER TO EXPLAIN IT TO YOU.

Roger Rienman McBee

ADDITIONAL NOTICE TO OREGON (USA) RESIDENTS:

Oregon law requires Oregon residents to use a specific form “to be valid”; however, Oregon law recognizes that forms not following the statute can be valid expressions of patient wishes and preferences. Here is the text of the statute, including the form:

127.531 Form of advance directive. (1) The form of an advance directive executed by an Oregon resident must be the same as the form set forth in this section to be valid. In any place in the form that requires the initials of the principal, any mark by the principal is effective to indicate the principal’s intent.

(2) An advance directive shall be in the following form:

ADVANCE DIRECTIVE

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts About Part B
(Appointing a Health Care Representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your “health care representative.” You can do this by using Part B of this form. Your representative must accept on Part E of this form.

You can write in this document any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About Part C
(Giving Health Care Instructions)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using Part C of this form.

Facts About Completing This Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an emergency, critical and advance care plan, you do not have to sign this form.

Unless you have limited the duration of this emergency, critical and advance care plan, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this emergency, critical and advance care plan will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

Special Notices and Information Regarding Healthcare Agents and Advance Directives

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Despite this document, you have the right to decide your own health care as long as you are able to do so.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes or add words that better express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTHDATE AND ADDRESS here:

_____
(Name)

_____
(Birthdate)

_____

_____
(Address)

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

Unless revoked or suspended, this emergency, critical and advance care plan will continue for:

INITIAL ONE:

_____ My entire life

_____ Other period (_____ years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint_____as my health care representative. My representative's address is _____and telephone number is_____.

I appoint_____as my alternate health care representative. My alternate's address is _____and telephone number is_____.

I authorize my representative (or alternate) to direct my health care when I can't do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption or that person was appointed before your admission into the health care facility.

1. Limits. Special Conditions or Instructions:

_____

_____

_____

INITIAL IF THIS APPLIES:

Roger Rienman McBee

_____ I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support. "Life support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

Roger Rienman McBee

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding. One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

_____
(Birthdate)

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

_____
(Signature of person making appointment)

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

• The term "as my physician recommends" means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.

• "Life support" and "tube feeding" are defined in Part B above.

• If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.

• You will get care for your comfort and cleanliness, no matter what choices you make.

• You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. Close to Death. If I am close to death and life support would only postpone the moment of my death:

A. INITIAL ONE:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

B. INITIAL ONE:

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

Roger Rienman McBee

_____ I want NO life support.

YOU DO NOT HAVE TO FILL OUT
AND SIGN THIS FORM

Roger Rienman McBee

2. Permanently Unconscious. If I am unconscious and it is very unlikely that I will ever become conscious again:

A. INITIAL ONE:

_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I DO NOT WANT tube feeding.

B. INITIAL ONE:

_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want NO life support.

3. Advanced Progressive Illness. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

A. INITIAL ONE:

_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I DO NOT WANT tube feeding.

B. INITIAL ONE:

_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want NO life support.

4. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

A. INITIAL ONE:

_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I DO NOT WANT tube feeding.

B. INITIAL ONE:

_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want NO life support.

5. General Instruction.

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

Roger Rienman McBee

INITIAL IF THIS APPLIES:

_____ I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. Additional Conditions or Instructions.

(Insert description of what you want done.)

7. Other Documents. A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE:

_____ I have previously signed a health care power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.

_____ I have a health care power of attorney, and I REVOKE IT.

_____ I DO NOT have a health care power of attorney.

(Date)

SIGN HERE TO GIVE INSTRUCTIONS

(Signature)

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART D: DECLARATION OF WITNESSES

We declare that the person signing this emergency, critical and advance care plan:

(a) Is personally known to us or has provided proof of identity;

(b) Signed or acknowledged that person's signature on this advance directive in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence;

(d) Has not appointed either of us as health care representative or alternative representative; and

(e) Is not a patient for whom either of us is attending physician.

Witnessed By:

Roger Rienman McBee

(Signature of (Printed Name Witness/Date) of Witness)

(Signature of (Printed Name Witness/Date) of Witness)

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

Special Notices and Information Regarding Healthcare Agents and Advance Directives

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NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this emergency, critical and advance care plan. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

PART E: ACCEPTANCE BY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this emergency, critical and advance care plan or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me.

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

(Signature of Health Care Representative/Date)

(Printed name)

(Signature of Alternate Health Care Representative/Date)

(Printed name)

Special Notices and Information Regarding Healthcare Agents and Advance Directives

Roger Rienman McBee

ADDITIONAL NOTICE TO WISCONSIN (USA) RESIDENTS:

NOTICE TO PERSON MAKING THIS DOCUMENT:

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONGTERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE OR DOMESTIC PARTNER AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED OR THE DOMESTIC PARTNERSHIP IS TERMINATED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOC- UMENT REVOKES ANY PRIOR RECORD OF GIFT THAT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.

IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.

MyDirectives®

HIPAA Authorization Form

Roger Rienman McBee

Important Note to readers of this document:

To verify that this document is the most current version available for Roger Rienman McBee, please click here, or go to https://qa.mydirectives.com/verify and enter this ID: **aeea122** and this check sum: **Wge2EgB0Ko**, or scan the QR code on the left.

ADVault, Inc., a Texas corporation ("ADVault"), is requesting *Roger Rienman McBee*, or his or her representative ("Patient"), to authorize the use and/or disclosure of certain Protected Health Information (as defined in U.S. Federal Regulations 45 CFR 164.501) between ADVault and hospitals and other medical treatment centers, as well as other third parties designated by Patient, subject to the requirements of the United States Federal Health Insurance Portability and Accountability Act of 1996 (each, a "Covered Entity"). The Protected Health Information for which authorization is requested can be specifically described as advanced medical directives and other indicators of patient treatment preference, including without limitation medical proxies, living wills, Do-Not-Resuscitate orders and organ donation forms, as well as the Patient's identifying information linking the Patient to the Protected Health Information and/or information related to Patient's current and future health care, medical history, treatment, or any other related information. Authorization for the use and/or disclosure of such Protected Health Information is requested for purposes of permitting ADVault to store and send to the Covered Entities, and the Covered Entities to provide ADVault, as well as to locate, retrieve, view and print, such advanced medical directives and Protected Health Information to determine the Patient's treatment preferences in a time of need. ADVault may disclose such Protected Health Information either directly to a Covered Entity or indirectly across an electronic health record, benefits verification or health information exchange platform in which ADVault participates.

Conditions

• The Patient agrees that ADVault and the Covered Entities may disclose the Patient's Protected Health Information to each other only for purposes listed above.

• Once the information above is released, the information may be subject to re-disclosure by ADVault or a Covered Entity and may not be protected under the privacy rules promulgated under the United States Federal Health Insurance Portability and Accountability Act of 1996.

• The Covered Entity will provide the Patient with a copy of the Protected Health Information for which this authorization is being sought upon the written request of the Patient.

• The Covered Entity may not condition treatment, payment, enrollment, or eligibility for benefits (as applicable) on whether the Patient signs this authorization.

• The Patient is voluntarily signing this authorization.

• The Patient will receive a copy of the signed authorization.

• This authorization will remain in effect until it is revoked by the Patient, and no further use or disclosure of the Patient's Protected Health Information is permitted to the above-stated person or entity beyond that date.

• The Patient has the right to revoke this authorization at any time. This revocation must be in writing, and submitted to the following address: ADVault, Inc., P.O. Box 832624, Richardson, Texas 75083, United States of America.

Roger Rienman McBee

• Once this authorization is revoked, ADVault and the Covered Entities will not use or disclose the Protected Health Information for the above-stated purpose except to the extent that ADVault or a Covered Entity has already relied on the authorization.

Signatures

Patient/Legal Representative: *Roger McBee* Date: *11/8/2016*

If Legal Representative, relationship to Patient: _____

Witness: _____ Date: _____

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Signing Certificate

Roger Rienman McBee

Important Note to readers of this document:
To verify that this document is the most current version available for Roger Rienman McBee, please click here, or go to https://qa.mydirectives.com/verify and enter this ID: **aeea122** and this check sum: **Wge2EgB0Ko**, or scan the QR code on the left.

HIPAA Release Authorization

Signed: 11/8/2016 10:43 AM CDT

Healthcare Agent Information Sheet

Signed: 11/8/2016 10:43 AM CDT

Enrollee: Roger Rienman McBee
Gender: Male
DOB: 4/1/1945

Address: 456 Vaultina Dr., Dallas, Texas 75219
Home: (214) 585-9878
Mobile: (214) 533-8525

Email: rogerb@testaccount.edu

Signature Certifications

Roger McBee

Electronic Signature
On file with MyDirectives®
Signed: 11/8/2016 10:43 AM CDT

My Thoughts Enhancements

My Likes / Joys
Video File URL: Enhancement/e549fd83
Dated: 9/18/2012 2:13 PM CDT

My End-of-Life Enhancements

Donation
Video File URL: Enhancement/879e7a28
Dated: 5/26/2014 2:42 PM CDT

My Thoughts Enhancements

Laughter
Image File URL: Enhancement/78417a33
Dated: 5/20/2014 3:13 PM CDT

My End-of-Life Enhancements

Autopsy
Pdf File URL: Enhancement/91f546b5
Dated: 7/7/2014 10:58 AM CDT

SIGNED, SECURE & ACTIVE

This icon indicates the enrollee has completed the MyDirectives® signing procedure.

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Signing Certificate

Roger Rienman McBee

To provide your hospital/healthcare provider with a link to an Official Copy of this document,
click "Send my uADD..." from your My Home page at www.mydirectives.com.

A|D Vault™

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or go to https://qa.mydirectives.com/verify and enter this ID: **aeea122** and this check sum: **Wge2EgB0Ko**, or scan the QR code on the left.

For more information, contact MyDirectives® at info@mydirectives.com or http://www.mydirectives.com