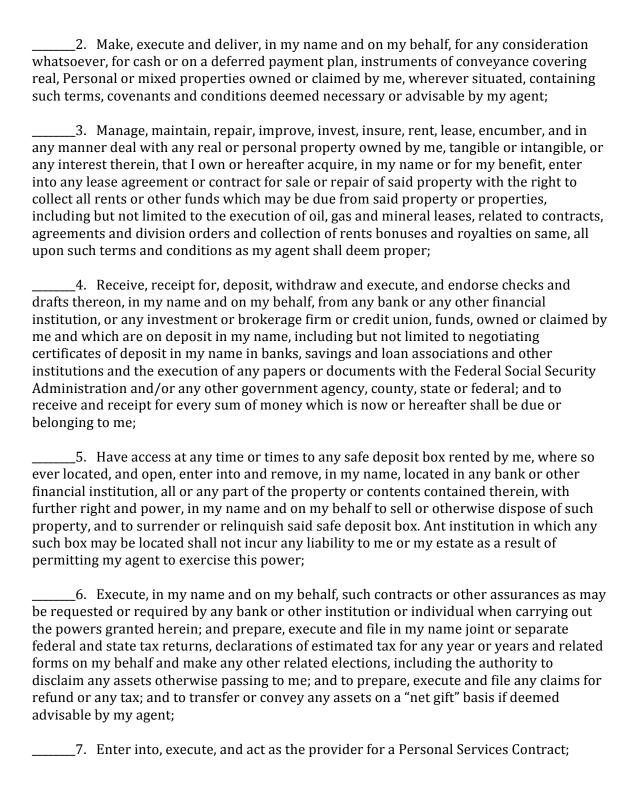
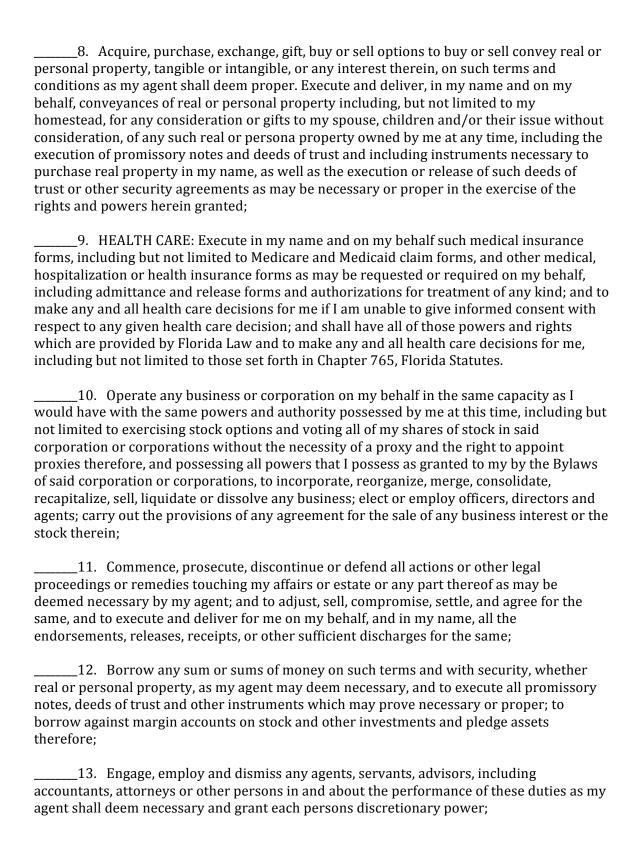


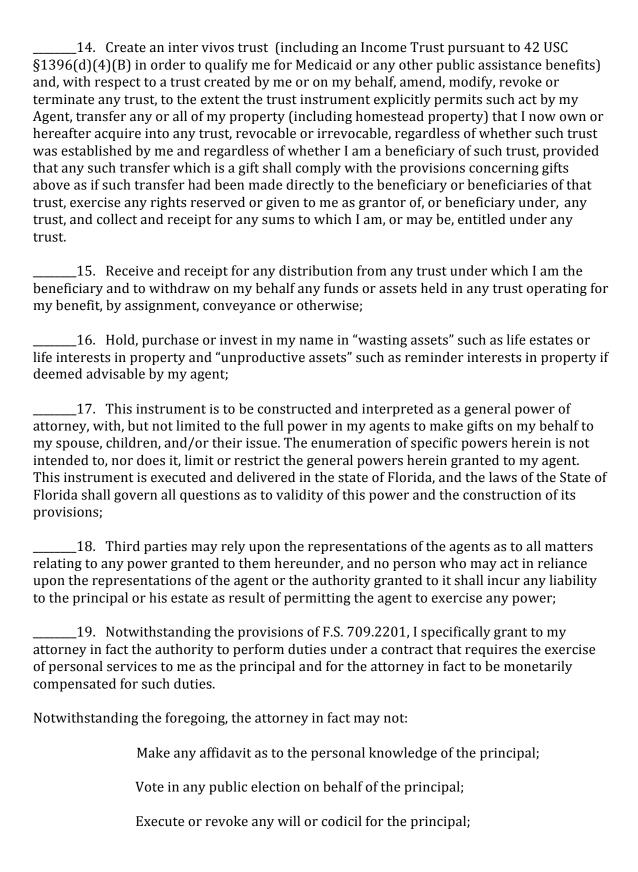
General Durable Power of Attorney:

Finances, Property, and Health Care (Florida Statutes 709.01 et seq.)

STATE OF FLORIDA
COUNTY OF
KNOWN BY ALL MEN BY THESE PRESENTS:
That I,, of, Florida,
That I,, of, Florida, being of sound mind and memory, do hereby make, constitute and appoint, as
my true and lawful agent(s) and attorney(s) in fact (hereinafter sometimes called "my agent"), with full power and authority to act for me, individually, and in my name, place and stead, with reference to the transaction of any and all businesses, do any and all things, exercise any discretion, and execute and deliver any and all conveyances and any other documents concerning me or my property, real or personal, or mixed, or affairs, as fully and completely as I might lawfully do if present and acting in person with full power of substitution or revocation, and to have all powers and rights that I now possess or may possess hereafter with respect to all of my property.
Without intending in any manner to limit or diminish the foregoing powers granted to my agent, but intending to expand or enlarge upon the same, I specifically authorize and empower my agent, to:
1. Forgive, request, demand, sue for, collect, receive, hold, purchase, invest and reinvest in, transfer, sell, convey, pledge all sums of money, dues, commercial paper, check, drafts, deposits, legacies, bequests, devises, notes, interest, stock certificates, bonds (including "Bearer Bonds"), dividends, certificates of deposit, annuities (private and public), pension, profit sharing, retirement, social security, disability, insurance and other contractual benefits and proceeds, all documents of title, all property, real or personal, intangible and tangible property and property rights, and demands whatsoever, liquidated, now or may hereafter owned by me, or due, owning, payable or belonging to me or in which I have or may hereafter acquire an interest;







Create, amend, modify, or revoke any document or other disposition effective at the principal's death or transfer assets to an existing trust created by the principal unless expressly authorized by the power of the attorney; or

Exercise powers and authority granted to the principal as trustee or as court-appointed fiduciary.

I direct that the above-related powers and authority of my said agent shall be exercisable and effective regardless of the fact that I may be mentally or physically incapacitated or incapable of understanding or unable to express myself or act on my own behalf at the time of any action on my behalf by said agent. Such incapacity, whether mental or physical, that I may exhibit shall not in any way interfere with the authority of my agent herein to act fully on my behalf according to the terms hereof. In other words, this Power of Attorney shall not be affected by subsequent disability, incompetence or incapacity of the principal.

And I do hereby undertake to ratify and confirm, all and singular, the acts heretofore performed and to be hereinafter performed by my said agents, acting in my name and on my behalf.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY 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 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 disclosure of this information; and (4) Consent to the donation of any of my 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 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 USC 1320d and 45 CFR 160-164. 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 clearing house that has provided treatment or services to me, 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 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 and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any prior agreement that I have made with my health-care providers to restrict access to or disclosure of my 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 health-care provider.

IN WITNESS WHEREFORE, I have exconsisting of pages this the _	day of		, 20 I
hereby revoke Powers of Attorney p Durable Power of Attorney executed			
Attorney for me.	a on this date is to	be the only only	mg Durable Fower of
Signed:			
	ATTESTATION	J	
The hereinafter named Witnesses, e the State of Florida that the principa and acknowledged this power of att of sound mind and under no duress, appointed as attorney in fact by this by blood, marriage or adoption, and part of the estate of the principal up operation of law.	al is personally kno orney in our prese , fraud or undue in document, and th to the best of our	own to us, that the ence, that the pri fluence, that we at we are not re knowledge, are	he principal signed incipal appears to be are not the person lated to the principal not entitled to any
Witness our signatures, this the	day of		_, 20
WITNESSES:			
		Of	
		Of	
		Of	
STATE OF FLORIDA COUNTY OF			
The foregoing instrument was acknown	owledged by me th	nis day of	f
20 by	who is/	are personally l	known by me or who
has/have produced:take an oath.		as identificat	ion and who did not
SEAL			
My Commission Expires:			
	Notary P State of F		
		2 	

Long Term Care Qualifications, LLC

727-724-9777