Document 2025 1700
Book 2025 Page 1700 Type 06 008 Pages 9
Date 7/02/2025 Time 2:22:48PM
Rec Amt $47.00
INDX
ANNO
SCAN
BRANDY MACUMBER. COUNTY RECORDER
MADISON COUNTY IOWA
CHEK

Power of Attorney
Title of Document (on/above line)

PREPARER INFORMATION:
(name, address, phone number)
Ann marie moreno
5010 Grand Ridge Dr, West Desmoines, IA 50265
515-222-5991

TAXPAYER INFORMATION:
(name and mailing address)

X

RETURN DOCUMENT TO:
(name and mailing address)
Charles Rautersberg
1412 E Boston Ave
Indianola, IA 50125

GRANTOR:
(name) Mary L Rautersberg

GRANTEE:
(name)
Charles Rautersberg

IOWA GENERAL DURABLE POWER OF ATTORNEY

This power of attorney shall not be affected by disability of the principal.

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions concerning your property for you (the principal). Your agent will be able to make decisions and act with respect to your property (including your money) whether or not you are able to act for yourself. The meaning of authority over subjects listed on this form is explained in the Uniform Power of Attorney Act.

This power of attorney does not authorize the agent to make health-care decisions for you.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you revoke the power of attorney or the agent resigns or is unable to act for you.

Your agent is entitled to reasonable compensation unless you state otherwise in the Special Instructions.

This form provides for designation of one agent. If you wish to name more than one agent you may name a coagent in the Special Instructions. Coagents are not required to act together unless you include that requirement in the Special Instructions.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

DESIGNATION OF AGENT

I Mary Rauterberg (Name of Principal) name the following person as my agent:

Name of Agent: Charles Rauterberg
Agent's Address: 1412 E Boston Ave Indianola, IA 50125
Agent's Telephone Number: 515-444-9111

DESIGNATION OF SUCCESSOR AGENT(S) (OPTIONAL)

If my agent is unable or unwilling to act for me, I name as my successor agent:

Name of Successor: Mark Rauterberg
Successor Agent's Address: 322 N 15th Ave Winterset, IA 50273
Successor Agent's Telephone Number: 515-344-1264

If my successor agent is unable or unwilling to act for me, I name as my second successor agent:

Name of Second Successor Agent: Anthony Rauterberg
Second Successor Agent's Address: _____
Second Successor Agent's Telephone Number: 515-473-0802

GRANT OF GENERAL AUTHORITY

I grant my agent and any successor agent general authority to act for me with respect to the following subjects as defined in the Uniform Power of Attorney Act:

(INITIAL each subject you want to include in the agent's general authority. If you wish to grant general authority over all of the subjects you may initial "All Preceding Subjects" instead of initialing each subject.)

(___) Real Property
(___) Tangible Personal Property
(___) Stocks and Bonds
(___) Commodities and Options
(___) Banks and Other Financial Institutions
(___) Operation of Entity or Business
(___) Insurance and Annuities
(___) Estates, Trusts, and Other Beneficial Interests
(___) Claims and Litigation
(___) Personal and Family Maintenance
(___) Benefits from Governmental Programs or Civil or Military Service
(___) Retirement Plans
(___) Taxes
(/) All Preceding Subjects

GRANT OF SPECIFIC AUTHORITY (OPTIONAL)

My agent MAY NOT do any of the following specific acts for me UNLESS I have INITIALED the specific authority listed below:

(CAUTION: Granting any of the following will give your agent the authority to take actions that could significantly reduce your property or change how your property is distributed at your death. INITIAL ONLY the specific authority you WANT to give your agent.)

(___) Create, amend, revoke, or terminate an inter vivos trust
(___) Make a gift, subject to the limitations of the Uniform Power of Attorney Act and any special instructions in this power of attorney
(___) Create or change rights of survivorship
(___) Create or change a beneficiary designation
(___) Authorize another person to exercise the authority granted under this power of attorney
(___) Waive the principal's right to be a beneficiary of a joint and survivor annuity, including a survivor benefit under a retirement plan
(___) Exercise fiduciary powers that the principal has authority to delegate
(___) Disclaim or refuse an interest in property, including a power of appointment

LIMITATION ON AGENT'S AUTHORITY

An agent that is not my ancestor, spouse, or descendant MAY NOT use my property to benefit the agent or a person to whom the agent owes an obligation of support unless I have included that authority in the Special Instructions.

SPECIAL INSTRUCTIONS (OPTIONAL)

You may give special instructions on the following lines:

_____
_____
_____
_____
_____
_____
_____
_____
_____

EFFECTIVE DATE

This power of attorney is effective immediately unless I have stated otherwise in the Special Instructions.

NOMINATION OF CONSERVATOR OR GUARDIAN (OPTIONAL)

If it becomes necessary for a court to appoint a conservator or guardian of my estate or guardian of my person, I nominate the following person(s) for appointment:

Name of Nominee for conservator or guardian of my estate:

_____

Nominee's Address: _____

Nominee's Telephone Number: _____

Name of Nominee for guardian of my person:

_____

Nominee's Address: _____

Nominee's Telephone Number: _____

RELIANCE ON THIS POWER OF ATTORNEY

Any person, including my agent, may rely upon the validity of this power of attorney or a copy of it unless that person knows it has terminated or is invalid.

SIGNATURE AND ACKNOWLEDGMENT

Mary R Rauterberg — 1/30/2025

Your Signature — Date

Mary Rauterberg

Your Name Printed

322 N 15th Ave Winterset, IA 50273

Your Address

515-344-6635

Your Telephone Number

STATEMENT OF WITNESS

On the date written above, the principal declared to me in my presence that this instrument is his general durable power of attorney and that he or she had willingly signed or directed another to sign for him or her, and that he or she executed it as his or her free and voluntary act for the purposes therein expressed.

WITNESS No. 1

Signature: _____

Printed Name: _____

Address: _____

_____

WITNESS No. 2:

Signature: _____

Printed Name: _____

Address: _____

_____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of Iowa
County of Polk

Acknowledged before me this 30 day of January (month), 2025 (year) by Mary Rauterburg (name of principal). The affiant is (choose one): ____ personally known to me, or ✓ produced the following identification: ID.

Ann Marie Moreno
Signature of Notary
My commission expires: 4/28/25

(Seal, if any)

NOTARIAL SEAL IOWA
ANN MARIE MORENO
Commission Number 839069
My Commission Expires
April 28, 2025

THE IOWA STATE BAR ASSOCIATION
Official Form No. 123

FOR THE LEGAL EFFECT OF THE USE OF THIS FORM, CONSULT YOUR LAWYER

DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES
(Living Will)
AND
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS
(Medical Power of Attorney)

I. DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES

If I should have an incurable or irreversible condition that will result either in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery, it is my desire that my life not be prolonged by the administration of life-sustaining procedures. If I am unable to participate in my health care decisions, I direct my attending physician to withhold or withdraw life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

This declaration is subject to any specific instructions or statement of desires I have added in "Additional Provisions" below.

II. POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I, Mary Rauterberg, born 10/13/1959, designate Charles Rauterberg 515.444.9111
1412 E Boston Ave Indianola, IA 50125
(Type or Print) Name of Agent, Street Address, City, State, Zip Code and Phone Number

as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of the State of Iowa, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document.

I hereby revoke all prior Durable Powers Of Attorney for Health Care Decision.

OPTIONAL: If the person designated as agent above is unable to serve, I designate the following person to serve instead:

Mark Rauterberg 515.344.1264 ; Anthony Rauterberg 515.473.0802
(Type or Print) Name of Alternate, Street Address, City, State, Zip Code and Phone Number

OPTIONAL: ADDITIONAL PROVISIONS - Insert specific instructions or statement of desires (if any):

YES ☐ NO ☒ In the event that medical professionals determine that I may be an organ donor, I agree to the use of life-sustaining procedures, including a ventilator, for the sole purpose and time period required to complete the organ donation. Nothing in this paragraph shall be construed to expand or detract from the laws related to anatomical gifts as outlined in the Iowa Code, Chapter 142C. The purpose of this paragraph is to practically and medically make organ donation possible.

Signed this 30 day of January, 2025

Your Signature (Declarant/Principal)

322 N 15th Ave
Winterset, IA 50273
Address, Street, City, State and Zip

Mary Rauterberg
Type or Print Your Name

IMPORTANT NOTE: THIS DOCUMENT MUST BE SIGNED OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR TWO WITNESSES. SEE REVERSE FOR NOTARY OR WITNESS FORMS. IF YOU WANT TO EXECUTE EITHER A LIVING WILL DECLARATION OR A MEDICAL POWER OF ATTORNEY, BUT NOT BOTH, SEPARATE FORMS ARE AVAILABLE FROM THE IOWA STATE BAR ASSOCIATION. IF YOU HAVE QUESTIONS REGARDING THIS FORM OR NEED ASSISTANCE TO COMPLETE IT, YOU SHOULD CONSULT AN ATTORNEY.

NOTARY PUBLIC FORM

STATE OF Iowa, COUNTY OF Polk ss:

This record was acknowledged before me this 30 day of January, 2025, by Mary Rautenburg.

ANN MARIE MORENO
Commission Number 839069
My Commission Expires
April 28, 2025

Signature of Notary Public

WITNESS FORM

We, the undersigned, hereby state that we signed this document in the presence of each other and the Declarant/Principal and we witnessed the signing of the document by the Declarant/Principal or by another person acting on behalf of the Declarant/Principal at the direction of the Declarant/Principal; that neither of us is appointed as attorney in fact by this document; that neither of us are health care providers who are presently treating the Declarant/Principal, or employees of such a health care provider. We further state that we are both at least 18 years of age, and that at least one of us is not related to the Declarant/Principal by blood, marriage or adoption.

Signature of First Witness	Signature of Second Witness
Type or Print Name of Witness	Type or Print Name of Witness
Street Address, City, State and Zip Code	Street Address, City, State and Zip Code

GENERAL INFORMATION REGARDING THIS DOCUMENT

1. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. "Life-sustaining procedure" means any medical procedure, treatment, or intervention which utilizes mechanical or artificial means to sustain, restore, or supplement a spontaneous vital function, and when applied to a person in a terminal condition, would serve only to prolong the dying process. "Life sustaining procedure" does not include administration of medication or performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.
2. The terms "health care" and "life-sustaining procedure" include nutrition and hydration (food and water) only when provided parenterally or through intubation (intravenously or by feeding tube). Thus, this document authorizes withholding nutrition or hydration that is provided intravenously or by feeding tube. If this is not what you want, you should set forth your specific instructions in the space provided on page 1.
3. The following individuals shall not be designated as the attorney in fact to make health care decisions under a durable power of attorney for health care:
   a. A health care provider attending the principal on the date of execution.
   b. An employee of such a health care provider unless the individual to be designated is related to the principal by blood, marriage, or adoption within the third degree of consanguinity.
4. The power of attorney for health care decisions or the declaration relating to use of life-sustaining procedures may be revoked at any time and in any manner by which the principal/declarant is able to communicate the intent to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending health care provider upon its communication to the provider by the principal/declarant or by another to whom the principal/declarant has communicated the revocation.
5. It is the responsibility of the principal/declarant to provide the attending health care provider with a copy of this document.
6. A declaration relating to use of life-sustaining procedures will be given effect only when the declarant's condition is determined to be terminal or the declarant is in a state of permanent unconsciousness, and the declarant is not able to make treatment decisions.

SUGGESTIONS AFTER FORM IS PROPERLY SIGNED, WITNESSED OR NOTARIZED

1. Place original in a safe place known and accessible to family members or close friends.
2. Provide a copy to your doctor.
3. Provide a copy(s) to family member(s).
4. Provide a copy to the designated attorney in fact (agent) and to alternate designated attorneys in fact (if any).

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO NOMINATED HEALTH CARE ATTORNEY-IN-FACT

Pursuant to the terms of a Durable Power of Attorney, Health Care Decisions, (or Combined Living Will and Medical Power of Attorney) (HCPOA) dated January 30, 2025, in which the undersigned is the grantor, the power becomes effective in the event of my disability or incapacity.

AUTHORIZATION TO RELEASE INFORMATION:

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 me or that has paid for or is seeking payment from me for such services, to give, disclose, and release to the person or persons designated in this document to act as my agent such of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition

(including all specially protected health information relating to each of the following conditions specifically authorized by me to be disclosed by marking the box with an "X" or a check mark:

- [X] sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV);
- [X] behavioral and mental health; and
- [X] alcohol, drug and other ~~substance~~ abuse)

Signature of Principal

1/30/2025
Date

relating to my ability to make health care decisions. The purpose of this request is to assist in determining whether the person designated to act as my agent should act as my agent. This authorization expires when I die or when revoked by me by a written revocation signed by me and delivered to the entity from which information is being requested prior to the time information is being requested.

I understand I can revoke this authorization by delivering a written statement of revocation to any entity I have authorized to give, disclose and release information. The revocation is effective only as to those entities to whom the written statement revocation is given and only after the time of delivery. I also understand that I have the right to inspect the disclosed information at any time. My treatment, payment, enrollment or eligibility for benefits with an entity that I have authorized to release information is not conditioned on my signing this authorization. I know that once the information I have authorized to be released is released it is subject to re-disclosure by the recipient and is no longer protected by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto, as amended from time to time.

THE AUTHORITY TO ACT AS PERSONAL REPRESENTATIVE

In addition to the other powers granted by the HCPOA, I grant to my agent the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and its regulations (HIPAA) during any time that my agent (hereinafter referred to in subsequent clauses of this paragraph as my "HIPAA personal representative") is exercising authority under this document.

Pursuant to HIPAA, I specifically authorize my HIPAA personal representative to request, receive and review any information regarding my physical or mental health, including without limitation all HIPAA-protected health information, medical and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required in order to obtain this information and to consent to the disclosure of this information. I further authorize my HIPAA personal representative to execute on my behalf any documents necessary or desirable to implement the health care decisions that my HIPAA personal representative is authorized to make under the HCPOA.

Dated this 30 day of January, 2025.

, Grantor