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INDX **ANNO SCAN** 

CHEK

LISA SMITH, COUNTY RECORDER MADISON COUNTY 10WA

Preparer Information:

(Individual's name, address and phone number)

Paul Goldsmith

9231/2 BRADEN

774-5989

CHARITON IA 50049

Taxpayer Information:

(Taxpayer's name and full mailing address)

Return Document To:

(Name and full mailing address)

CURTIS CATRON

48849 2707 AUE.

CHARITON, IA 50049

Grantors:

Grantees:

EVA JEAN CATRON

CURTIS D CATRON

Parcel Identification Number:

(If required or applicable)

Legal Description:

Document or instrument number of associated documents previously recorded:



## **DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES**

(Living Will)

#### **AND**

# DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(Medical Power Of Attorney)

# **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.

Provisions" below.	s subject to any sp	becine instructions o	statement or desire	s i nave added in Additiona				
II. POWER OF A	TTORNEY FOR H	EALTH CARE DECI	<u>SIONS</u>					
I hereby designate	Curtis D. Catron	Print) Name of Agen						
48849 270th Avenue	Phone Number							
(Type or Print) Stre	eet Address	City	Sta	ate Zip Code				
power exists only whe	n I am unable, in	the judgment of m	y attending physiciar	h care decisions for me. This n, to make those health care n this document or otherwise				
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 docume I hereby revoke all p		rs Of Attornev for He	alth Care Decisions.					
				gnate the following person to				
(Type or Print) Nam	e of Alternate			Phone Number				
(Type or Print) Stree	et Address	City	State	zip Code				
OPTIONAL: ADDITION	IAL PROVISIONS	- Insert here specific	instructions or statem	nent of desires (if any):				
		·	.*	, ,				
	<b>7</b> .	. 10						
Signed this	day	of Hug		<i>a</i>				
P. O. Box 473		<del></del> -	Eva Jea	en Cation				
Street Address Earlham, IA 50072			our Signature Øeclara a Jean Catron	ant/Principal)				
City			pe or Print Your Nam	 ne				
IMPORTANT NOTE: WITNESSES. SEE R EITHER A LIVING W	THIS DOCUMENTEVERSE FOR NOW ILL DECLARATION ARE AVAILABLE RDING THIS FO	NT MUST BE SIGNOTARY OR WITON OR A MEDICAL FROM THE IOWA	INED BEFORE A INESS FORMS. IF AL POWER OF AT A STATE BAR ASS	NOTARY PUBLIC OR TWO YOU WANT TO EXECUTE ITORNEY, BUT NOT BOTH SOCIATION. IF YOU HAVE MPLETE IT, YOU SHOULD				

## NOTARY PUBLIC FORM

STATE OF	IOWA	, COUNTY	OF Mad	115an	ss:	
This by <u>Eva Jean</u>		cknowledged before	e me on	8-2	, 2009	
Declarant/Princip person acting on appointed as atto reating the Decla	oal and we witnes behalf of the Dec orney in fact by the arant/Principal, or	pires WITN Watate that we sign of the signing of the signing of the sign of th	f the documer he direction of neither of us a a health care p	nt by the Declarant the Declarant/Princ are health care prov provider. We further	e of each other and the /Principal or by another ipal; that neither of us is riders who are presently state that we are both at al by blood, marriage or	
Signature of First Witness			Signature of Second Witness			
(Type or Print Name of Witness)			(Type or Pr	(Type or Print Name of Witness)		
Street Address			Street Addr	ress		
City	State	Zip Code	City	State	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, 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:						
$\underline{X}$ sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV); $\underline{X}$ behavioral and mental health; and $\underline{X}$ alcohol, drug and other substance abuse) $\underline{X}$ Signature of Principal  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 Z day of Aug., 2009.

Eva Jean Cation