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DURABLE POWER OF ATTORNEY FOR HEALTH CARE
OF
JOSEPH R. NOGOSKY

ARTICLE I
Designation of Health Care Agent

I, Joseph R. Nogosky, as Principal and as a resident of the State of Alabama, hereby appoint the following person to serve as my Agent to make health and personal care decisions for me as authorized in this document:

Melanie Altizer (my niece)
Address: 4798 Black Hollow Rd, Dublin, VA 24084
Phone: (540) 674-4292

Additionally, my Agent shall act as guardian/conservator or limited guardian/conservator of my person, should guardianship/conservatorship proceedings become necessary or desirable.

ARTICLE II
Effectiveness and Durability

By signing this document, I intend to create a durable power of attorney for health care under Sections 26-1-2 and 22-8A-4, et seq., of the Code of Alabama also known as the Alabama Natural Death Act. It shall take effect upon my incapacity to make my own health care decisions, shall survive such incapacity or disability and shall continue during incapacity to the extent permitted by law or until revoked. For purposes of this document, incapacity shall mean my inability to exercise informed medical consent. This shall include my inability to exercise rational judgment regarding my health care or to understand the risks, benefits, and alternatives involved in particular health care decisions. For purposes of this Power of Attorney, determination of incapacity shall not require a judicial finding of incapacity.

ARTICLE III
Purpose

I am signing this document in recognition of my fundamental right to control the decisions relating to my medical care; that those rights belong equally to the competent as well as the incompetent; that modern medical technology has made possible the prolonging of life and/or postponement of death; and in recognition that such prolonging of life and/or postponement of death may cause loss of dignity and unnecessary pain and suffering while providing nothing medically necessary or beneficial.

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ARTICLE IV
Powers Regarding Health Care Decision and Over the Person of the Principal

I grant to my Agent full authority to make decisions for me regarding my health care. In exercising this authority, my Agent shall follow my desires as stated in this document or otherwise known to my Agent. In making any decision, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If I am unconscious, comatose, senile, or otherwise unreachable by such communication, my Agent should make the decision guided primarily by my preferences as expressed in this document, any preferences which I may have previously expressed and as expressed in any Health Care Directive, Directive to Physicians, or "Living Will" that I have executed.

Accordingly, unless specifically limited below, my Agent shall have the authority to make all the health care decisions to the same extent I could make for myself if I had the capacity to do so, including, without limitation, the following:

A. Health Care Decisions; Consent. To consent to giving, withholding or stopping any treatment, service, or procedure to diagnose, maintain, or treat my physical or mental condition; consent to my medical and surgical care and non-treatment, including experimental forms of treatment or procedures; consent to the withholding or withdrawal of life-sustaining treatment and to make any and all health care decisions on my behalf and to sign forms necessary to carry out health care decisions.

B. Employ and Discharge Others. To employ and discharge physicians, psychiatrists, dentists, nurses, therapists, and other professionals as my Agent may deem necessary for my physical, mental and emotional well-being or to advise or assist the Agent in the performance of his/her duties.

C. Fees and Costs. To pay reasonable and necessary fees and costs incurred in carrying out the powers and duties under this document, including reasonable reimbursement from my assets for the costs advanced by my Agent.

D. Agreement Regarding Care. To enter into any agreement for my care.

E. Arrange for My Care. To arrange for my hospitalization, convalescent care, or home care. I ask my Agent to be guided in making such decisions by what I have told my Agent about my personal preferences regarding such care, and by any Health Care Directive that I have executed.

F. Right to Refuse Treatment. To summon paramedics or other emergency medical personnel and seek emergency treatment for me, or choose not to do so, as my Agent deems appropriate given my wishes, any Health Care Directive that I may have executed and my medical status at the time of the decision; to sign documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical

Advice," as well as any necessary waivers of or releases from liability required by the hospitals or physicians to implement my wishes regarding medical treatment or non-treatment; request and concur with the writing of a "no-code" (DO NOT RESUSCITATE) order by the attending or treating physician.

G. Health Care Records; Medical Information. To have access to all my medical and health care records, and to consent to the disclosure of such records pursuant to the Uniform Health Care Information Act with the same power and authority that I would have to authorize such disclosure; to obtain any information whatsoever regarding my personal affairs or physical or mental health from any person, including any physician, hospital, nurse, medical attendant, technician or health care or nursing facility or personnel, psychiatrist, psychologist, counselor, therapist or drug or alcohol counselor or personnel from any drug and alcohol or mental health facility, or other health care provider, and I waive any privilege to such information in favor of my Agent.

H. Withdrawal of Consent to Treatment. To revoke or change any consent previously given or implied by law to any medical care or treatment.

I. Execute Documents. To sign, execute, deliver and acknowledge such documents in writing of whatever kind and nature as may be necessary or proper in accordance with the powers granted herein, including (but not limited to) granting any waiver or release of liability required by any hospital, physician, or other health care provider.

J. Legal Action. To pursue any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my Agent, or to seek damages for the failure to comply.

K. Exercise and Protect Rights. To exercise my right of privacy and to make decisions regarding medical treatment even though the exercise of these rights may hasten my death or be against conventional medical advice and to exercise such powers and constitutionally or otherwise protected rights as I would have if competent.

L. Provide Me Relief From Pain. To consent to and arrange for the administration of pain-relieving drugs of any type or other surgical or medical procedures calculated to relieve my pain, even though their use might lead to permanent physical damage, addiction, or even hasten the moment of my death.

M. Make Advance Funeral Arrangements. To make advance arrangements for my funeral, burial or cremation, including the purchase of a burial plot and marker, and such other related arrangements provided I have not already done so.

N. Grant Releases. To grant releases to hospital staff, physicians, nurses and other medical and hospital administrative personnel who act in reliance on instructions given by the Agent or who render written opinions to my Agent from all liability from damages suffered or to be suffered by me, to sign documents titled or purporting to be a

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"Refusal in Treatment" or "Leaving Hospital Against Medical Advice," as well as any necessary waivers of or releases from liability required by a hospital or physician to implement my wishes regarding medical treatment or non-treatment.

O. Companionship and Visitation. To provide for companionship for me and to be accorded the status of a family member for purposes of visitation and access to me in any health care facility, emergency vehicle, or other setting in which the right to be present may be restricted to family members.

P. Autopsy. To authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law.

Q. Consent or Refuse Consent to My Psychiatric Care. My Agent may arrange for my admission to a hospital or institution for treatment of a diagnosed mental health problem or disorder, arrange for private psychiatric and/or psychological treatment; refuse any such treatment; revoke, modify, or withdraw the consent that my Agent or I may have earlier given. Such action may only be taken when two (2) independent psychiatrists licensed to practice in the state of my residence and who have examined me, have executed certificates that in his/her opinion I am in immediate need of hospitalization or other mental health intervention or treatment because of mental disorders, alcoholism, or drug abuse. When any Agent named herein, in good faith, has reason to believe that I may be incapacitated, he or she may contact my treating physician or any treating psychiatrist or therapist and I give my permission to my physician, psychiatrist and/or therapist to discuss my situation and condition to the extent it is necessary to determine whether or not I am incapacitated by reason of acute psychiatric illness or other such impairment. Treatment for the purpose of this paragraph is defined as therapy, psychological or psychiatric treatment, hospitalization, placement in an institution for mental health, drug or alcohol treatment, or any other such related treatments.

ARTICLE V
Health Care Directive

The Agent shall take into account and honor my wishes as reflected in any Health Care Directive, Directive to Physicians, or similar "Living Will" executed by me, and shall have the power to interpret my intent as to the meaning of said Directive or "Living Will."

ARTICLE VI
Substituted Judgment/Best Interest

In exercising the powers granted in this document, the Agent shall make a substituted judgment for me to do what I would do if I was competent to make a decision and understood all the circumstances, including my present and future competency

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regarding any matter relating to the rendering of medical, health and/or nursing care to me. But if the Agent is unable to make such a substituted judgment for me on those matters, the Agent shall act according to a good faith determination by the Agent as to my best interests regarding decisions for my medical, health and/or nursing care.

ARTICLE VII
Reliance; Protection of Third Parties Relying on My Agent

No person acting in good faith and in reasonable reliance on this document shall incur any liability thereby. All persons dealing with my acting Agent hereunder shall rely on the apparent authority of the Agent, unless they have actual knowledge of invalidity in the execution or revocation of this document.

ARTICLE VIII
Nomination of Guardian/Conservator

It is my intent to avoid the necessity of Guardianship or Conservator proceedings and the power given to my Agent herein should be broadly construed to accomplish such purpose. If the appointment of a Guardian, Conservator or Limited Guardian of my person is sought, I nominate my Agent (or his/her successor) named above to serve as Guardian, Conservator or Limited Guardian of my person. If the designation of guardian hereunder shall conflict with the designation of guardian under any other Power of Attorney executed by me, then the guardian/conservator under this Power of Attorney shall control as to guardian/conservator of my person.

My Agent and any person appointed by the court as my Guardian/Conservator or Limited Guardian shall not deny visitation to my close friends, and shall give him/her/them first priority in visitation. Such contact from my supportive, loving, and caring friends is necessary to my well-being. This clause may be specifically enforced by any person or class of persons identified in this paragraph, or by such person's guardian/conservator or limited guardian.

If any person other than my first above named Agent ("primary Agent") is appointed as Guardian/Conservator or Limited Guardian of my person, my primary Agent shall have the power and authority at any time to replace said person as Guardian/Conservator or Limited Guardian, unless a court then finds good cause against her/his appointment.

ARTICLE IX
Addition to Medical Record.

This document shall be made a part of my permanent medical record upon my admission to a health care facility.

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ARTICLE X
Administrative Provisions

A. Revocation. I revoke any prior Power of Attorney for health care and designations of guardian over my person that I have previously executed.

B. Jurisdiction. This Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The laws of the State of Alabama shall govern this Power of Attorney.

C. Compensation. My Agent shall not be entitled to compensation for services performed under this Power of Attorney, but he/she shall be entitled to reimbursement, without Court order, for all reasonable expenses incurred as a result of carrying out any provision of this Power of Attorney. My estate shall hold harmless and indemnify my Agent from all liability for acts done in good faith.

D. Severability. In the event any of the provisions herein are deemed to be invalid or unenforceable, such invalid or unenforceable provision(s) are severable and shall not affect the validity of any other power granted herein or provision of this Power of Attorney.

E. Photocopies. Photocopies of this document are as valid as the original.

F. HIPAA Release Authority. I intend for my agent to 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 (aka 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 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 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 may 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.

G. Additional Provisions. I authorize and direct any physician, surgeon, nurse, hospital or other medical personnel or care facility to do the following: give my agent first priority in visitation should I be unable to express a preference because of my illness or disability and be a patient in any hospital, health care facility, hospice or other institution; and give him/her all personal property that may be recovered from or about my person at the time of my illness, disability or death.

By signing this document, I indicate that I understand the purpose and effect of this Durable Power of Attorney for Health Care, and the effect of this grant of powers to my Agent.

DATED this 6TH day of May, 2009.

Joseph R. Nogosky, Principal

Social Security Number: [redacted]
Residing at:
1011 Independence Dr.
Alabaster, AL 35007

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the health care agent or proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least nineteen years of age and am not directly responsible for paying for his or her medical care.

5/6/09
[Date]

[Witness Signature]

Ronald Eugene Osborne
[Print Name]
1432 Eden Ridge Drive
Hoover, Alabama 35244

5/6/09
[Date]

[Witness Signature]

Giovanni Bucciarelli
[Print Name]
431 Russet Hill Rd
Hoover, AL 35244

Signature of Agent/Proxy

I, Melanie Altizer, am willing to serve as the health care agent.

Signature: Melanie Altizer Date: 5-6-09

Notary

My Commission Expires Oct. 19, 2010