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Shelby Cnty Judge of Probate, AL  
02/12/2010 01:56:34 PM FILED/CERT

**This**  
**HEALTH CARE POWER OF ATTORNEY**  
**prepared for**  
**MARTHA P. COX**




**Jennifer Q. Griffin**  
**Kendall Maddox & Associates, LLC**  
**2550 Acton Road, Ste 210**  
**Birmingham, AL 35243**  
**Phone: (205) 977-9045 / Fax: (205) 977-9049**  
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# Health Care Power of Attorney

of

MARTHA P. COX

  
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## I. Designation of Health Care Agent

I, MARTHA P. COX, of 8500 Highway 51, Westover, Shelby County, Alabama 35147, do hereby designate the first person(s) named on the following list as my Attorney(s)-in-Fact (my "Agent" or Co-Agents, as the case may be; and, unless the context indicates otherwise, any reference to my Agent herein shall also refer to any Co-Agent) and the subsequent person(s) named on the following list as successor(s) to such Agent(s) in the order in which their names appear:

JANNINE C. GORE

LORRAINE C. FANCHER

all as my Attorney-in-Fact who shall act as my Agent to make health care decisions for me as authorized in this document.

## II. Effective Date; Duration

This power of attorney shall become effective upon the disability, incompetency, or incapacity of the principal. This power of attorney shall operate if I become incapacitated to make my own decisions about my health care, and shall continue to operate as long as I am incapacitated to make whatever decisions related to my health care are under consideration.

Incapacity shall be determined by agreement between my attending physician and my Agent. If my physician believes I retain capacity but my Agent disagrees, then my Agent may choose a consulting physician to examine me. I direct my attending physician to allow any such examination and to talk with the consulting physician. The consulting physician's judgment as to my incapacity shall be determinative.

This power of attorney shall remain effective as long as I am legally alive, or until I revoke it in writing, and the authority conferred herein shall not be affected by my disability, incompetency or incapacity.

## III. Agent's Powers

I grant my Agent full authority to make decisions for me regarding my health care. I intend that my Agent have, and be able to exercise, the broadest powers for health care decision making that I myself have by law, including, but not limited to, the following:

- A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration and cardiopulmonary resuscitation;
- B. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;
- C. To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living or similar facility or service;
- D. To contract on my behalf for any health care related service or facility, without my Agent incurring personal financial liability for such contracts;
- E. To employ and discharge medical, social service, and other support personnel responsible for my care;
- F. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death;
- G. To make anatomical gifts of any or all of my body organs for medical purposes, authorize an autopsy, and provide for the disposition of my remains, to the extent permitted by law;
- H. To take any other action necessary to do what I authorize herein, including (but not limited to) granting any waiver or release from liability require by any hospital, physician, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing 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 actual or punitive damages for the failure to comply;
- I. Withdrawing consent to intervention already in use, whether started with my or my Agent's consent (for example, treatment started in emergency circumstances if I was incapacitated, my Agent was not available to consent, and neither my Agent, nor I when able to make my own decisions, had previously refused consent to the particular treatment).

#### **IV. Protection of Third Parties**

No person who relies in good faith upon representation by my Agent or Successor Agent shall be liable to me, my estate, my heirs or assigns, for acting upon the Agent's authority.





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## **V. Guardianship**

If Guardianship proceedings are instituted for any reason, I nominate my Agent to be my guardian and I consent to such appointment. If my Agent cannot serve, then I nominate my Successor Agent. I oppose appointment of anyone other than one of these two people, unless at the time of guardianship proceedings neither of them is willing and able to serve.

If someone other than my Agent or Successor Agent is appointed guardian, I ask that the court in the order appointing guardian require the guardian to act in accord with my wishes as stated in this document.

## **VI. Administrative Provisions**

- A. I hereby revoke any prior power of attorney for health care.
- B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.
- C. My Agent shall not be entitled to compensation for services performed under the power of attorney, but he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this power of attorney.
- D. The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect the others.

By signing here I indicate that I understand the contents of this document and the effect of this grant of powers to my Agent.

I sign my name to this Health Care Power of Attorney on this September 30, 2009.

  
MARTHA P. COX



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# WITNESS STATEMENT

I declare that MARTHA P. COX is personally known to me, that she signed or acknowledges this durable health care power of attorney in my presence, and that she appears to be of sound mind and under no duress, fraud, or undue influence. I did not sign the principal's signature above for or at the direction of the principal and I am over the age of nineteen years. I am not appointed as Agent by this document, nor am I the patient's health care provider, or any employee of the patient's health care provider. I further declare that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge, I am not a creditor of the principal nor entitled to any part of her estate according to the laws of intestate succession or under any Will of the principal or codicil thereto, nor directly financially responsible for the principal's medical care.

Heckia Harvey  
 Witness

2550 Acton Road, Ste 210  
 Street Address

Birmingham, AL 35243  
 City, State, Zip Code

[Signature]  
 Witness

2550 Acton Road, Ste 210  
 Street Address

Birmingham, AL 35243  
 City, State, Zip Code

STATE OF ALABAMA )  
 ) SS  
 COUNTY OF JEFFERSON )

On this September 30, 2009, the said MARTHA P. COX, known to me to be the person named in the foregoing instrument, personally appeared before me, a Notary Public in said County and State, and acknowledged that she executed the same freely and voluntarily for the purposes stated therein.

Jennifer Q. Griffin  
 Notary Public

My commission expires: 10/4/2010

Prepared by:  
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