STATE OF ALABAMA)
SHELBY COUNTY)

20190923000346880 1/8 $43.00
Shelby Cnty Judge of Probate, AL
09/23/2019 09:51:36 AM FILED/CERT

DURABLE POWER OF ATTORNEY
for Health Care and Living Will

KNOW ALL MEN BY THESE PRESENTS, THAT I, **Claudia H. Maxwell**, presently residing in the State of Alabama, and being an adult of sound mind, do hereby revoke all prior living wills and make, constitute, appoint and authorize **Kelly Griffin,** as my true and lawful Attorney in Fact (hereinafter referred to as "Attorney-in-Fact"), to act in my name, place and stead and on my behalf and for my use and benefit, to do, perform and execute all and every act that I may legally do, perform and execute through an Attorney-in-Fact for the limited purpose of making health care decisions for and on my behalf including the power to make and communicate any and all decisions about or relating to my receipt or refusal to accept medical treatment, hospitalization, possible surgical procedures, health care or personal care, or other medical treatments, in any situation in which, as the result of illness, disease, mental deterioration or injury, I am incapable of making or communicating such decisions for myself.

I grant to my Attorney-in-Fact full authority to act as my health care proxy and to make decisions for me regarding my health care and direct my physician and other health care providers to follow the instructions of my Attorney-in-Fact hereunder. In exercising this authority, my Attorney-in-Fact shall follow my desires as stated in this document or otherwise known to my said Attorney-in-Fact. In making any decision, my Attorney-in-Fact shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Attorney-in-Fact cannot determine the choice I would want made, then my Attorney-in-Fact shall make a choice for me based upon what my Attorney-in-Fact, after consultation with my attending physician, believes to be in my best interests. I understand that I am authorizing my Attorney-in-Fact to withhold or withdraw certain treatments that may lead to my death. My Attorney-in-Fact's authority to interpret my desires is intended to be as broad as possible.

HIPAA POWERS

My Attorney-in-Fact under this instrument is hereby designated as my "Personal Representative" as defined by 45 CFR 164.502, otherwise known as the Health Insurance Portability and Accountability Act of 1996, as amended, or HIPAA. My Personal Representative may view my medical records, execute releases of confidential information from medical providers and insurers or third parties, and shall be considered my Personal Representative for health care disclosure under HIPAA. This authorization and consent to disclosure shall apply whether or not I continue to have the capacity to give informed consent, and is effective immediately. I further consent to and direct covered entities to provide my health care information to my Personal Representative at any time upon his/her request.

I intend for my Attorney-in-Fact 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 health care provider or 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 Attorney-in-Fact, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

The HIPAA authority given my Attorney-in-Fact 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 HIPAA authority given my Attorney-in-Fact 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.

OTHER HEALTHCARE PROVISIONS

I further delegate to my Attorney-in-Fact the power and authority to select, employ and discharge health care personnel, such as physicians, nurses, therapists, home health care providers and other medical professionals, and to contract in my name and on my behalf for all health care services, including without limitation, medical, nursing and hospital care, as my Attorney-in-Fact may deem appropriate. I confirm that I shall be and remain personally liable for the payment of all such care and services to the same extent as if I had personally contracted therefor.

I further authorize my Attorney-in-Fact to request, receive and review any information regarding my physical and mental health, including without limitation medical and hospital records; to execute on my behalf any releases or other documents that may be required in order to obtain this information; and to consent to the disclosure of this information. I authorize my Attorney-in-Fact to execute on my behalf any documents necessary or desirable to implement the health care decisions that my Attorney-in-Fact is authorized to make pursuant to this document, including without limitation all documents pertaining to a refusal to permit medical treatment, or authorizing the leaving of a medical facility against medical advice, or any waivers or releases from liability required by a physician or health care provider. Accordingly, my Attorney-in-Fact is authorized as follows:

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, nutritional support and hydration and cardiopulmonary resuscitation (even if withholding or withdrawing such support and hydration causes me pain);

b. To execute on my behalf any releases or other documents that may be required in order to obtain or review any records or information regarding my physical and mental health;

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 for any health care related service or facility on my behalf, without said Attorney-in-Fact incurring personal financial liability for such contracts;

e. To select, employ and discharge medical, social service and other support and health care personnel responsible for my care;

f. To make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law;

g. To take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required 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 said Attorney-in-Fact, or to seek actual or punitive damages for the failure to comply;

h. To execute on my behalf any documents necessary or desirable to implement the health care decisions that my Attorney-in-Fact is authorized to make pursuant to this document;

i. To direct the health care provider responsible for my care to transfer my care to another health care provider who will comply; and if this authority is thwarted, undermined, or not honored to its fullest extent, to initiate action for battery against such providers; and

j. To implement pain management techniques in my care.

No person, physician, institution or health care provider who relies in good faith upon any representations or instructions by my Attorney-in-Fact shall be liable to me, my estate, my heirs or assigns, for recognizing said Attorney-in-Fact's authority.

It being my intent to be cared for in my home for as long as reasonably and medically possible, I authorize my Attorney-in-Fact to do all such acts and things as shall be necessary to provide for my care and medical treatment in my home and to avoid my admission to any long-term

care facilities; to do all such acts and things as shall be necessary to carry out my wishes including but not limited to providing for the hiring, managing and procuring of medical personnel in caring for me in my home; purchasing convalescent care equipment for my needs at home; and modifying the physical structure of my home in order to accommodate my convalescent care.

LIVING WILL

If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized, and where the application of life-sustaining procedures would serve only to artificially prolong the dying process; or, in the event that there is no hope of my recovery, as evidenced by a written medical opinion, **and only after my Attorney in Fact is convinced that all reasonable medical procedures have been exhausted and that the continuation of life-sustaining treatment is futile**, then my Attorney in Fact shall be authorized to express my right to refuse and direct the withdrawal of medical treatment which would prolong my life, and to communicate health care decisions to all persons, including without limitation my physicians, health care providers and family. Upon the occurrence of the circumstances of my health as set forth in this Paragraph, I direct that my Attorney in Fact shall assure that life-sustaining procedures be withheld or withdrawn, including artificial means of nutrition and hydration, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. The procedures and treatment to be withheld or withdrawn include, without limitation, surgery, antibiotics, cardiac and pulmonary resuscitation, respiratory support, and artificially administered feeding and fluids.

Upon the happening of the above circumstances, and in the absence of my ability to give directions regarding making such health care decisions or the use of such life-sustaining procedures, it is my intention that the provisions of the Living Will section of this Durable Power of Attorney for Health Care and Living Will shall then be in full force and effect, and it is my further intention that the declarations contained herein shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment, and accept the consequences of such refusal.

I understand the full import of this declaration, and I am aware that this declaration authorizes a physician to withhold and withdraw life-sustaining procedures. I am at least nineteen years of age and I am emotionally and mentally competent to make this declaration.

I do hereby give and grant to my aforenamed Attorney-in-Fact hereunder, every proper power necessary to assure that the purposes for which this Durable Power of Attorney for Health Care and Living Will is granted are carried out, hereby ratifying and confirming each and every act which my said Attorney-in-Fact shall do by virtue of the power herein conferred on same.

This instrument is to be construed and interpreted as a general Power of Attorney. The enumeration of specific items, rights, acts, or powers herein is not intended to, nor does it, limit or restrict, and is not to be construed or interpreted as limiting or restricting, the general powers herein granted to my said Attorney-in-Fact.

In the event of the death, resignation, or inability of **Kelly Griffin** to serve, I appoint **Nathan Stamps** to serve as my successor Attorney-in-Fact to act in my name, place and stead with all rights, powers and authority as herein granted to my original Attorney in Fact.

This document shall be considered a Durable Power of Attorney and shall take effect on the 15th *day of* November*, 2018, and shall continue in existence during any period in which I am incapacitated or unable to act for myself. This Power of Attorney shall not be affected by the passage of time.*

The HIPAA authority and all other powers given my Attorney-in-Fact 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 HIPAA authority and all other powers given my Attorney-in-Fact have 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 WHEREOF, I have executed, as Principal, this Durable Power of Attorney for Health Care and Living Will, as my free and voluntary act and deed, this 15th day of November, 2018.

Claudia Maxwell

Claudia H. Maxwell

WITNESSES

(1) The foregoing instrument was personally signed by the Declarant in my presence, and thereupon I, at the Declarant's request and in the presence of the Declarant and in the presence of the other witnesses, have hereunto subscribed my name as a witness; (2) I did not sign the Declarant's signature above for or at the direction of the Declarant; (3) The Declarant has been personally made known to me and I believe the Declarant to be of sound mind and under no constraint, duress, fraud or undue influence; (4) I am not related to the Declarant by blood, marriage or adoption; (5) I am not entitled (to the best of my knowledge and belief) to any portion of the estate of the Declarant according to the laws of intestate succession or under any Will or Codicil of the Declarant; (6) I do not have any present inchoate claim against any portion of the estate of the Declarant; (7) I do not have any financial responsibility for the medical care of the Declarant; (8) I am not a physician or an employee of any physician, and I am not an operator or employee of, or patient in, any hospital, health care provider, residential care facility, community care facility or similar institution in which the Declarant is a patient; (9) I am not a person named as Attorney-in-Fact in this instrument; and (10) I and the Declarant are both at least 19 years of age.

Dated: 15th day of November, 2018.

WITNESS:

Lynn Campisi

ADDRESS OF WITNESS:

3016 Pump House Road

Birmingham, AL 35243

WITNESS:

Deborah H. Oliver

Deborah H. Oliver

ADDRESS OF WITNESS:

3016 Pump House Road

Birmingham, AL 325243

ACKNOWLEDGMENT

STATE OF ALABAMA)
JEFFERSON COUNTY)

I, the undersigned, a Notary Public in and for said County in said State, hereby certify that **Claudia H. Maxwell**, whose name is signed to the foregoing Durable Power of Attorney for Health Care and Living Will, and who is known to me, acknowledged before me on this day that, being informed of the contents of said Durable Power of Attorney for Health Care and Living Will, she executed the same voluntarily on this 15th day of November, 2018.

Given under my hand and official seal this 15th day of November, 2018.

Catherine M. Mills
Notary Public
My commission expires: 11/2/22

(SEAL)

CATHERINE M. MILLS
MY COMMISSION EXPIRES
NOVEMBER 2, 2022
NOTARY PUBLIC
STATE OF ALABAMA

20190923000346880 7/8 $43.00
Shelby Cnty Judge of Probate, AL
09/23/2019 09:51 36 AM FILED/CERT

ACCEPTANCE OF ATTORNEY-IN-FACT

I, **Kelly Griffin**, accept the Attorney-in-Fact designation of the Declarant.

Date: 9-18-19

Kelly Griffin
Kelly Griffin, Attorney-in-Fact

Shelby County, AL

Address: 1050 Overland Road
Montevallo, Al. 35115

I, **Nathan Stamps,** accept the Successor Attorney-in-Fact designation of the Declarant.

Date: _____

Nathan Stamps
Nathan Stamps, Successor Attorney-in-Fact

Address: 142 Calmont Woods Drive
Montevallo, AL 35115

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