2023 Doc# 372224 1 of 21
Tallapoosa, Alabama Talmadge East, PROBATE J
UDGE 6/1/2023 2:16:35 PM TRAN 178442 REC $7
4.00 POWER OF ATTORNEY $74.00

STATE OF ALABAMA)
TALLAPOOSA COUNTY)

20230608000172780 1/21 $82.00
Shelby Cnty Judge of Probate, AL
06/08/2023 11:11:13 AM FILED/CERT

REVOCATION OF POWER OF ATTORNEY FOR HEALTHCARE AND LIVING WILL, ADVANCE DIRECTIVE FOR HEALTHCARE AND HIPAA RELEASE AUTHORITY

KNOW ALL MEN by these presence, which are intended to constitute a revocation of a Durable Power of Attorney, that I, **Lisa Lea Duke**, presently residing in Tallapoosa County, Alabama hereby make the following declaration:

1) I acknowledge that on October 19, 2015, I signed a Durable Power of Attorney For Healthcare and Living Will, Advance Directive for Healthcare and HIPAA Release Authority in which I appointed as my Attorney in Fact and Healthcare Proxy, **Joy Ann Hardin** to exercise certain powers for me, attached hereto as Exhibit A.

2) I hereby revoke any and all said appointments of Attorney in Fact and Healthcare Proxy and further revoke in its entirety all provisions as stated in any Durable Power of Attorney For Healthcare and Living Will, Advance Directive for Healthcare and HIPAA Release Authority of **Lisa Lea Duke** in which I appointed **Joy Ann Hardin** as my Attorney in Fact or Healthcare Proxy. I further certify that I have notified my said Attorney in Fact or Healthcare Proxy that any and all said Durable Power of Attorney For Healthcare and Living Will, Advance Directive for Healthcare and HIPAA Release Authority for **Lisa Lea Duke** have been revoked by placing a copy of this Revocation in the U.S. Mail, First Class, addressed to my designated Attorney in Fact as follows:

Joy Ann Hardin
417 Water Oak Run
Jackson Gap, AL 36861

IN WITNESS WHEREOF, I have executed this Revocation of Durable Power of Attorney executed by me on this 24th day of May, 2023.

Lisa Lea Duke
Lisa Lea Duke

20230608000172780 2/21 $82.00
Shelby Cnty Judge of Probate, AL
06/08/2023 11:11:13 AM FILED/CERT

WITNESS:

Jennifer Q. Griffon
Jennifer Q. Griffon

Address:

3016 Pump House Rd
Birmingham AL 35243

WITNESS:

Joanna Leigh Jones
Joanna Leigh Jones

Address:

3016 Pump House Rd
Birmingham AL 35243

ACKNOWLEDGMENT

STATE OF ALABAMA)
Jefferson **COUNTY**)

I, the undersigned, a notary public, hereby certify that **Lisa Lea Duke**, whose name is signed to the foregoing Revocation of Durable Power of Attorney, and who is known to me, acknowledged before me on this day that, being informed of the contents of said power of attorney, she executed the same voluntarily on this 24th day of May, 2023.

Given under my hand and official seal this 24th day of May, 2023.

Catherine M. Mills
Notary Public
My commission expires: 11/2/26
(SEAL)

CATHERINE M MILLS
MY COMMISSION EXPIRES
NOVEMBER 2, 2026
NOTARY PUBLIC
STATE OF ALABAMA

EXHIBIT A

20230608000172780 3/21 $82.00
Shelby Cnty Judge of Probate, AL
06/08/2023 11:11:13 AM FILED/CERT

STATE OF ALABAMA)
JEFFERSON COUNTY)

DURABLE POWER OF ATTORNEY
for Health Care and Living Will

KNOW ALL MEN BY THESE PRESENTS, THAT I, **LISA LEA DUKE,** 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 **JOY ANN HARDIN** 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. This 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 to 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, healthcare 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 on my behalf 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; and

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. **It being my intent to be cared for in my home for as long as reasonably and medically possible, 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;**

j. 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, I initiate action for battery against such providers; and

k. No person, physician, institution or healthcare 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.

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, 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; **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**. 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 and 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 and 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 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.

And 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 to serve of **JOY ANN HARDIN,** then I appoint **KATHY REED** as my successor Attorney in Fact to act in my place with all of the aforementioned powers.

This document shall be considered a Durable Power of Attorney and shall take effect on the 19th *day of* October, *2015, 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 effected 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 19th day of October, 2015.

Lisa Lea Duke

LISA LEA DUKE

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 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: 19th day of October, 2015.

WITNESS:

Lynn Campisi

ADDRESS OF WITNESS:

3008 Pump House Road

Birmingham, AL 35243

WITNESS:

Kim McConnell

ADDRESS OF WITNESS:

3008 Pump House Road

Birmingham, AL 35243

20230608000172780 9/21 $82.00
Shelby Cnty Judge of Probate, AL
06/08/2023 11:11:13 AM FILED/CERT

ACKNOWLEDGMENT

STATE OF ALABAMA)
JEFFERSON COUNTY)

I, the undersigned, a Notary Public in and for said County in said State, hereby certify that **LISA LEA DUKE**, 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 19th day of October, 2015.

Given under my hand and official seal this 19th day of October, 2015.

Catherine M. Mills
Notary Public
My commission expires: 11/2/18

(SEAL)

CATHERINE M. MILLS
MY COMMISSION EXPIRES
November 2, 2018
NOTARY PUBLIC
STATE OF ALABAMA

20230608000172780 10/21 $82.00
Shelby Cnty Judge of Probate, AL
06/08/2023 11:11:13 AM FILED/CERT

ACCEPTANCE OF ATTORNEY IN FACT

I, **JOY ANN HARDIN**, accept the attorney in fact designation of the Declarant.

Date: _____

_____
JOY ANN HARDIN, Attorney In Fact

Address: _____

_____

I, **KATHY REED**, accept the successor attorney in fact designation of the Declarant.

Date: _____

_____
KATHY REED, Successor Attorney In Fact

Address: _____

_____

Document prepared by
Lynn Campisi, Attorney at Law
Lynn Campisi, P.C.
3008 Pump House Road
Birmingham, AL 35243
(205) 967-1010
Pursuant to Alabama Code
Section 22-8A-2 et. seq.

ADVANCE DIRECTIVE FOR HEALTH CARE

This Advance Directive for Health Care is made this 19th day of October, 2015 I, **LISA LEA DUKE**, being 19 years of age or older, of sound mind, hereby revoke any prior advance directive for health care, and in lieu thereof hereby willfully and voluntarily make known my desires by my living will, or by my appointment of a health care proxy, or both, **only after my health care proxy is convinced that all reasonable medical procedures have been exhausted and that the continuation of life- sustaining treatment is futile**, that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

I. DEFINITIONS

As used in this Advance Directive for Health Care, the following terms have the meaning set forth below:

(A) ARTIFICIALLY PROVIDED NUTRITION AND HYDRATION. A medical treatment consisting of the administration of food and water through a tube or intravenous line, where I am not required to chew or swallow voluntarily. Artificially provided nutrition and hydration does not include assisted feeding, such as spoon or bottle feeding.

(B) LIFE-SUSTAINING TREATMENT. Any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to me, would serve only to prolong the dying process where I have a terminal illness or injury, or would serve only to maintain me in a condition of permanent unconsciousness. These procedures shall include, but are not limited to, assisted ventilation, cardiopulmonary resuscitation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs and antibiotics. Life-sustaining treatment shall not include the administration of medication or the performance of any medical treatment where, in the opinion of the attending physician, the medication or treatment is necessary to provide comfort or to alleviate pain.

(C) PERMANENT UNCONSCIOUSNESS. A condition that, to a reasonable degree of medical certainty:

(1) Will last permanently, without improvement;

(2) In which thought, sensation, purposeful action, social interaction, and awareness of self and environment are absent;

(2) Which condition has existed for a period of time sufficient, in accordance with applicable professional standards, to make such a diagnosis; and

(4) Which condition is confirmed by a physician, who is qualified and experienced in making a diagnosis.

(D) TERMINALLY ILL OR INJURED PATIENT. A patient whose death is imminent or whose condition, to a reasonable degree of medical certainty, is hopeless unless he or she is artificially supported through the use of life-sustaining procedures.

II. LIVING WILL

If my attending physician determines that I am no longer able to give directions to my health care providers regarding my medical treatment, I direct my proxy to instruct my attending physician and other health care providers to provide, withhold, or withdraw certain treatment from me under the circumstances I have indicated below. I understand that I am authorizing the withholding or withdrawal of certain treatments and this may lead to my death. I understand that I will be given treatment that is necessary for comfort or to alleviate my pain except where I specifically request otherwise.

(A) TERMINAL ILLNESS OR INJURY. If my attending physician and another physician determine that I have an incurable terminal illness or injury which will lead to my death within six (6) months or less:

(1) I do NOT want life-sustaining treatment which would not cure me but which would only prolong the dying process.

In addition, before life-sustaining treatment is withheld or withdrawn as directed above, I direct that my attending physician shall discuss with the following persons the benefits and burdens of taking such action and my stated wishes in this advance directive: **My Health Care Proxy.**

(2) I understand that artificially provided nutrition and hydration (tube feeding of food and water) may be necessary to preserve my life.

(3) I do NOT want artificially provided nutrition and hydration even if withholding or withdrawing causes me pain.

In addition, before artificially provided nutrition and hydration are withheld or withdrawn as directed above, I direct that my attending physician shall discuss with the following persons the benefits and burdens

of taking such action and my stated wishes in this advance directive: **My Health Care Proxy.**

(4) I direct that (add other medical directives, if any) (if none, state "none"): **none.**

(B) PERMANENT UNCONSCIOUSNESS. If in the judgment of my attending physician and another physician, I am in a condition of permanent unconsciousness:

(1) I do NOT want life-sustaining treatment which would not cure me but which would only maintain me in a condition of permanent unconsciousness.

In addition, before life-sustaining treatment is withheld or withdrawn as directed above, I direct that my attending physician shall discuss with the following persons the benefits and burdens of taking such action and my stated wishes in this advance directive: **My Health Care Proxy.**

(2) I understand that artificially provided nutrition and hydration (tube feeding of food and water) may be necessary to preserve my life.

(3) I do NOT want artificially provided nutrition and hydration even if withholding or withdrawing causes me pain.

In addition, before artificially provided nutrition and hydration are withheld or withdrawn as directed above, I direct that my attending physician shall discuss with the following persons the benefits and burdens of taking such action and my stated wishes in this advance directive: **My Health Care Proxy.**

(4) I direct that (add other medical directives, if any) (if none, state "none): **none.**

III. APPOINTMENT OF MY HEALTH CARE PROXY

I understand that my health care proxy is a person whom I may choose here to make medical treatment decisions for me as described below.

I DO want to appoint a health care proxy. If my attending physician determines that I am no longer able to give direction to my health care providers regarding my medical treatment, I direct my attending physician and other health care providers to follow the instructions of **JOY ANN HARDIN,** whom I appoint as my health care proxy, to act with all powers as provided under the Alabama Uniform Durable Power of Attorney Act. If **JOY ANN HARDIN** is unable to serve, I appoint **KATHY REED** as my alternate health care proxy to act with the same authority. My health care proxy is authorized to make whatever medical treatment decisions I

could make if I were able, including decisions regarding the withholding or withdrawing of life-sustaining treatment.

My Health Care Proxy 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. This "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 to 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) I specifically authorize my health care proxy to make decisions regarding whether artificially provided nutrition and hydration be withheld or withdrawn.

(ii) I specifically direct my health care proxy to (add other medical directives, if any) (if none, state "none"): **none**.

IV. CONFLICTING PROVISIONS

If the decisions made by the person I have appointed as my health care proxy disagree with the instructions in my Living Will:

I want the person I have appointed as my health care proxy to make the final decision.

V. HIPAA RELEASE

I intend for my Health Care Proxy 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, healthcare 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 Health Care Proxy, 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 Health Care Proxy 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 Health Care Proxy 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.

VI. OTHER PROVISIONS

(a) I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, directions in this advance directive for health care concerning the providing, withholding, and withdrawal of life-sustaining treatment and artificially provided nutrition and hydration shall have no force or effect during the course of my pregnancy.

(b) In the absence of my ability to give directions regarding the use of life-sustaining treatment, it is my intention that this Advance Directive for Health Care shall be honored by my family, my physician(s), and health care provider(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

(c) I understand the full import of this declaration and I am emotionally and mentally competent to make this Advance Directive for Health Care.

(d) Nothing herein shall be construed as a directive to exclude from consultation or notification any relative of mine about my health condition or dying. Written directive by me as to whether to notify or consult with certain family members shall be respected by health care workers, attorneys in fact, or surrogates.

(e) I understand that I may revoke this Directive at any time.

Signed Lisa Lea Duke
LISA LEA DUKE

Birmingham, Shelby County, Alabama

Date 10-19-15

The Declarant has been personally known to me and I believe her to be of sound mind. I did not sign the Declarant's signature above for or at the direction of the Declarant and I am not appointed as the health care proxy herein. I am not related to the Declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of the Declarant or codicil thereto, or directly financially responsible for the Declarant's medical care.

Witness _____

Witness _____

Date 10-19-15

I, **JOY ANN HARDIN,** accept the proxy designation of the Declarant.

Signed_____
JOY ANN HARDIN

Date _____

I, **KATHY REED,** accept the alternate proxy designation of the Declarant.

Signed_____
KATHY REED

Date _____

20230608000172780 18/21 $82.00
Shelby Cnty Judge of Probate, AL
06/08/2023 11:11:13 AM FILED/CERT

STATE OF ALABAMA)
COUNTY OF JEFFERSON)

HIPAA RELEASE AUTHORITY

KNOW ALL MEN BY THESE PRESENTS, THAT I, **LISA LEA DUKE**, presently residing in the State of Alabama, and being an adult of sound mind, do make, constitute, appoint and authorize **JOY ANN HARDIN,** to act as my "Personal Representative."

I intend for my Personal Representative 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, healthcare 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 Personal Representative, 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 authority given my Personal Representative 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 Personal Representative 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.

In the event of the death, resignation, or inability to serve of **JOY ANN HARDIN,** then I appoint the **KATHY REED** to serve as my successor Personal Representative to act in my place with all of the aforementioned authority.

The death, resignation or inability to serve of my Personal Representative shall be certified solely by the written statement of my successor Personal Representative or by the statement of the attending physician of my Personal Representative who may no longer act on my behalf.

IN WITNESS WHEREOF, I have executed, as Principal, this HIPAA Release Authority, as my free and voluntary act and deed, this 19th day of October, 2015.

Lisa Lea Duke

LISA LEA DUKE

20230608000172780 20/21 $82.00
Shelby Cnty Judge of Probate, AL
06/08/2023 11:11:13 AM FILED/CERT

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 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 interstate 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 Personal Representative in this instrument; and (10) I and the Declarant are both at least 19 years of age.

Dated: 19th day of October, 2015.

WITNESS:

Lynn Campisi

WITNESS ADDRESS:

3008 Pump House Road
Birmingham, AL 35243

WITNESS:

Kim McConnell

WITNESS ADDRESS:

3008 Pump House Road
Birmingham, AL 35243

20230608000172780 21/21 $82.00
Shelby Cnty Judge of Probate, AL
06/08/2023 11:11:13 AM FILED/CERT

ACCEPTANCE OF PERSONAL REPRESENTATIVE

I, **JOY ANN HARDIN,** accept the Personal Representative designation of the Declarant.

Date: _____

_____
JOY ANN HARDIN
Address: _____

_____

I, **KATHY REED,** accept the Successor Personal Representative designation of the Declarant.

Date: _____

_____
KATHY REED
Address: _____

_____