

GENERAL POWER OF ATTORNEY OVER HEALTH CARE DECISIONS AND HIPAA AUTHORIZATION

STATE OF MARYLAND :
 : ss
COUNTY OF MONTGOMERY :

I, Elton John, of Potomac, Maryland, do hereby make, constitute and appoint my domestic partner, David Furnish, for me and in my name, place and stead, on my behalf and for my use and benefit as my health care agent. If David Furnish is not then living or has been adjudged to be incompetent to serve as my health care agent at the time decisions regarding my health care must be made, I designate my friend, Hannibel Lechter of Rockville, Maryland, as alternate health care agent for me and in my name, place and stead for all the purposes herein provided. If Hannibel Lechter is not then living or has been adjudged to be incompetent or is not reasonably available to serve as my health care agent at the time decisions regarding my health care must be made, I designate my friend, Jack Kevorkian of Detroit, Michigan, as alternate health care agent for me and in my name, place and stead for all the purposes herein provided. **My agents' contact information appears at the end of this document.**

1. My health care agent is empowered to make all decisions and act in my stead with regard to my health care at any time that I may be, for any reason, including but not limited to my physical or mental disability, incapable of making decisions on my own behalf.

2. I grant to said health care agent full power and authority to do and perform all and every act and thing whatsoever requisite, proper or necessary to be done in the exercise of the rights herein granted, as fully to all intents and purposes as I might or could do if personally present and

able, with full power of substitution or revocation, hereby ratifying and confirming all that said health care agent shall lawfully do or cause to be done by virtue of this power of attorney and the rights and powers granted herein. Such power and authority shall include, but not be limited to:

3. My health care agent is further authorized to direct the withholding or withdrawal of life-sustaining procedures or measures in circumstances including, but not limited to, when and if I am: (a) terminally ill; (b) in an end-stage condition; (c) in a persistent vegetative state or coma for more than sixty (60) days; or (d) suffering from advanced Alzheimer's or similar disease. Life-sustaining procedures or measures are those forms of medical care which only serve to artificially prolong the dying process and may include cardio-pulmonary resuscitation, mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration and other forms of medical treatment which stimulate or maintain vital bodily functions. Life-sustaining procedures do not include care necessary to provide comfort or alleviate pain.

4. In the event I have an incurable injury, disease or illness and it has been determined that my death is imminent and will occur whether or not life-sustaining procedures are utilized and where the application of such procedures would serve only to artificially prolong the dying process, I direct my health care agent to authorize the withholding or withdrawal of such procedures. It is my intention that I be permitted to die naturally with only the administration of medication, the administration of food and water naturally and not artificially and the performance of any medical procedure that is necessary to alleviate pain and to provide me with comfort, dignity and supportive care. If I am unconscious or otherwise unable to communicate with my health care agent, then my health care agent's decision should be guided by taking into account (1) the foregoing provisions of this paragraph, (2) any preferences that I may previously have expressed in writing on the subject.

Any written expression of my intent, including any declaration regarding life-sustaining procedures that I have executed or may execute in the future, including my Advance Medical Directive, signed on this same date, shall be cumulative in effect with this document and shall not restrict the powers recited herein), (3) what my health care agent believes I would want done in the circumstances if I were able to express myself, and (4) any information given to my health care agent by the physicians treating me as to my medical diagnosis and prognosis.

9. HIPAA Release Authority.

9.1 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 and all information governed by the Health Insurance Portability and Accountability Act of 1996, 42 USC §1320d and 45 CFR 160-164 (hereinafter referred to as “HIPAA”).

9.2 For these purposes, my Agent shall be deemed to be my personal representative, as that term is used in the HIPAA regulations.

9.3 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, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually-transmitted diseases, mental illness and drug or alcohol abuse.

9.4 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.

10. In the event that any medical or care facility where I may be staying from time to time limits visitors to "close family members," I hereby state that I consider my domestic partner, David Furnish to be my closest family member and request that he be allowed to visit me at any time. I also request that the facility where I am staying allow David Furnish and my then-acting health care agent, if David Furnish is not then acting as my agent, to provide the names of other individuals whom I then consider to be close personal friends and that such people also be allowed to visit me freely.

(a) I acknowledge that visitors are sometimes limited by a facility "in the best interests of a patient" to allow the patient quiet time to rest, etc. However, I would prefer visitors in any event and in order to encourage the facility in which I may be staying to allow my friends to visit freely, I hereby expressly and without reservation provide that such facility shall incur no liability to me,

Date

Elton John

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THIS IS A SAMPLE OF SOME OF THE PROVISIONS THAT MIGHT BE CONTAINED IN A POWER OF ATTORNEY. IT IS DISTRIBUTED FOR EDUCATIONAL PURPOSES ONLY. IT IS NOT INTENDED AS A GUIDE OR AS AN ACTUAL POWER OF ATTORNEY AND IT IS NOT LEGALLY SUFFICIENT UNDER MARYLAND LAW.