ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code §4701)

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a co-worker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or discharge health care providers and institutions.

(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

(e) Make anatomical gifts, authorize an autopsy and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs, tissues and parts following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person

you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1

POWER OF ATTORNEY FOR HEALTH CARE

1.1. DESIGNATION OF AGENT. I designate Gary John as my agent to make health care decisions for me.

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate George Chavez as my alternate agent.

1.2. AGENT'S AUTHORITY. My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

_____

(Add additional sheets if needed)

1.3. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE. My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

If I mark this box □, my agent's authority to make health care decisions for me takes effect immediately.

1.4. AGENT'S OBLIGATION. My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

1.5. AGENT'S POSTDEATH AUTHORITY. My agent is authorized to donate my organs, tissues, and parts, authorize an autopsy and direct disposition of my remains, except as I state here or in Part 3 of

this form:

If I have executed, either concurrently with the execution of this Directive or at any time in the future, written "Final Disposition Instructions", I direct that my agent and family follow these instructions for my disposition arrangements.

_____

_____

_____

_____

(Add additional sheets if needed)

1.6. GRANT OF AUTHORITY TO MY AGENT AND AUTHORIZATION UNDER HIPAA AND CALIFORNIA LAW FOR THE INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive, to the extent I could do so, individually identifiable any information, verbal or written, regarding my physical or mental health, including, but not limited to, 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 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160-164, and the California Confidentiality of Medical Information Act ("CMIA"), California Civil Code §56. I hereby 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 individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition. For the purpose of complying with §56.11 of the California Civil Code, I have executed a form entitled AUTHORIZATION AND WAIVER FOR THE INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH concurrently herewith. This authority given my agent shall supersede any other agreement which I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. This authority given my agent shall be effective immediately, 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;

(b) Execute any and all releases or other documents that may be required in order to obtain this information;

(c) Consent to the disclosure of this information;

(d) Appoint a "Patient Advocate" for me who shall have the same right to ask questions and obtain information as my agent under this form; and,

(e) Transfer my care to another health care provider if my health care provider refuses to honor my Advance Health Care Directive. I also direct and empower my agent under this form to pursue any appropriate actions against my health care provider(s) in the event my Advance Health Care Directive is not honored.

1.7. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. When necessary to implement the health care decisions that my agent is authorized by this form to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice" and;

(b) Any necessary waiver or release from liability required by a hospital or physician.

1.8. NOMINATION OF CONSERVATOR. If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form to serve as such conservator. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated above.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

2.1. END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

□ (a) Choice Not to Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

□ (b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

2.2. FREEDOM FROM PAIN. Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

_____

_____

(Add additional sheets if needed)

2.3. OTHER WISHES. (If you do not agree with any of the optional choices above and wish to write

your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

If I ever fall into a persistently vegetative state, I wish my misery to be reduced as painlessly as possible.

If I become senile, I wish to die naturally and without any extraordinary medical treatment.

If I am in an irreversible coma or persistent vegetative state, I do not want any form of cardio-pulmonary resuscitation ("CPR").

If I am already in an irreversible coma or persistent vegetative state and I develop some other illness or condition for which an additional course of treatment would be considered, I do not want any additional treatment to be initiated (for example, if I am in an irreversible coma and it is subsequently discovered that I have cancer, I do not want surgery, chemotherapy and/or radiation).

_____

_____

_____

_____

(Add additional sheets if needed)

PART 3

DONATION OF ORGANS, TISSUES AND PARTS AT DEATH

(OPTIONAL)

3.1 □ Upon my death, I give my organs, tissues or parts (mark box to indicate yes):By checking the box above, and notwithstanding my choice in Part 2 of this form, I authorize my agent to consent to any temporary medical procedures necessary solely to evaluate and/or maintain my organs, tissues, and/or parts for purposes of donation.

My donation is for the following purposes (strike any of the following you do not want):

(a) Transplant

(b) Therapy

(c) Research

(d) Education

If you want to restrict your donation of an organ, tissue, or part in some way, please state your restriction on the following lines:

_____

_____

_____

If I leave this part blank, it is not a refusal to make a donation. My state-authorized donor registration should be followed, or, if none, my agent may make a donation upon my death. If no agent is named above, I acknowledge that California law permits an authorized individual to make such a decision on my behalf. (To state any limitation, preference, or instruction regarding donation, please use the lines above or in Section 1.5 of this form).

PART 4

MISCELLANEOUS

4.1 EFFECT OF COPY. A copy of this form has the same effect as the original.

4.2 SIGNATURE. Sign and date the form here:

_____ Dated: _____, 20__

John Davis Smith

4542 Ruffner Street Suite 300

San Diego, California

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of California (1) that John Davis Smith, the individual who signed or acknowledged this advance health care directive is personally known to me (or that his identity was proven to me by convincing evidence), (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly. I further declare under perjury under the laws of California that I am not related to the individual executing this advance health care directive document by blood, marriage or adoption and, to the best of my knowledge, I am not entitled to any part of the individual's estate upon his death under a will now existing or by operation of law.

_____ _____

[signature] [street address]

_____ _____

[please print name] [city, state]

_____ _____

[signature] [street address]

_____ _____

[please print name] [city, state]

AUTHORIZATION AND WAIVER FOR THE INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

(California Civil Code §56)

A. I, **John Davis Smith**, do hereby authorize the persons named below in Paragraphs B and C, individually and severally, to have the power and authority to do all of the following:

(1) Request, review, and receive, to the extent I could do so individually, any information, verbal or written, regarding my physical or mental health, including, but not limited to, 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 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160-164, and the California Confidentiality of Medical Information Act ("CMIA"), California Civil Code §56. I hereby 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 (hereinafter the "covered provider/entity"), to give, disclose, and release to the persons named herein without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition.

This authority shall supersede any other agreement which I may have made with any covered provider/entity to restrict access to or disclosure of my individually identifiable health information. This authority shall be effective immediately and shall expire two (2) years following my death unless I revoke the authority in writing and deliver such revocation to a covered provider/entity;

(2) Execute on my behalf any releases or other documents that may be required in order to obtain this information;

(3) Consent to the disclosure of this information;

(4) Bring legal action to enforce this Authorization if it is not honored.

B. The specifically named persons who shall have the powers hereinabove described in Paragraph A are:

Gary John

George Chavez

C. In addition to the persons who are specifically named in Paragraph B, the following described persons shall also have the powers hereinabove described in Paragraph A:

Any Trustee or Successor/Alternate Trustee of any inter-vivos trust created by me wherein I am a Trustee and/or a beneficiary.

Any agent (or "attorney-in-fact") in any General Power of Attorney created by me as the "Principal".

D. I understand the information used, disclosed, or released pursuant to this Authorization may be subject to re-disclosure by the authorized recipients whose names or positions are contained herein. No covered provider/entity shall require such authorized recipients to indemnify the covered provider/entity or agree to perform any act in order for the covered provider/entity to comply with this Authorization.

E. A copy or facsimile of this Authorization shall be accepted as though it were the original and I am aware that I am entitled to a copy of this Authorization.

F. I hereby release any covered provider/entity that relies on this Authorization from any liability that may accrue from the use, release, or disclosure of my private information.

This Authorization and Waiver is executed by me on _____, 20___, in _____ County, California.

_____

John Davis Smith

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.
STATE OF CALIFORNIA

COUNTY OF _____

On _____, 20___, before me, _____, a Notary Public, personally appeared John Davis Smith, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

_____

Notary Public Signature Notary Public Seal