LIMITED HEALTH-CARE POWER OF ATTORNEY

-- get notarized --

KNOW ALL MEN BY THESE PRESENTS, that _____ (Name of Mother) & _____ (Name of Father), (hereafter collectively referred to as Parents) are natural or adoptive parents of _____ (Name of Child), an un-emancipated minor (hereafter "Child"), and do hereby jointly nominate, constitute and appoint: _____ (Name of Attorney) as their attorney in fact for the limited purpose of making health-care decisions (including but not limited to providing informed consent for medical treatment, surgical and diagnostic procedures and records privacy decisions) on behalf of Child.

Parents do hereby jointly give and grant unto said attorney in fact full power and authority to do and perform every act necessary, requisite or proper to be done in and about the premises as fully as they might or could do were they personally present, with full power of substitution and revocation, hereby ratifying and confirming all that said attorney shall lawfully do or cause to be done by virtue hereof, with the following limitations:

1. This limited power of attorney shall be effective only if: a) Parents are unable to make health-care decisions regarding Child; or b) neither parent can be immediately located by telephone at their places of residence or businesses, as follows:

2. Parents fully understand that this designation will permit the attorney in fact to make health-care treatment and informational privacy decisions on behalf of Child, and to provide, withhold, or withdraw consent on Child's behalf; to apply for public benefits to defray the cost of health care; and to authorize Child's admission to or transfer from a health-care facility.

3. If the attorney in fact is unwilling or unable to perform his or her duties, Parents designate as alternate attorney in fact:

4. This limited power of attorney is not intended to and shall not pre-empt the provisions of Federal HIPAA Omnibus Rule 2013, pertaining to, respectively, consent for emergency care and other persons who may consent to medical care or treatment of a minor.

5. This limited power of attorney shall remain in full force and effect until revoked in writing, dated and signed by Parents.

6. A copy of this signed, dated power of attorney shall be as valid as the original.

IN WITNESS WHEREOF, the undersigned have issued this limited power of attorney, effective stated below,

_____ _____

Print Name of Parent Signature of Parent

_____ _____

Print Name of Parent Signature of Parent

On this _____ day of _____, 20_____, before me personally appeared _____ and _____, to me personally known and known to me to be the persons described in and who executed the foregoing instrument and they duly acknowledged that they executed same.

_____

Notary Public

My Commission Expires: _____