

**APPENDIX H**  
**LIMITED POWER OF ATTORNEY TO MANAGE LAW PRACTICE**  
**AT A FUTURE DATE**

I, \_\_\_\_\_ (name of principal), residing at \_\_\_\_\_, an attorney licensed and in good standing to practice law in the State of New York, with offices located at \_\_\_\_\_, do hereby appoint \_\_\_\_\_ (name of Agent), residing at \_\_\_\_\_, an attorney licensed and in good standing to practice law in the State of New York, with offices located at \_\_\_\_\_, as my agent and attorney-in-fact to act for me, in my name and in my behalf as hereinafter provided. This limited power of attorney shall become and remain effective, however, only upon and during a period of my incapacity by reason of my disappearance, disability, or other inability to act which renders me incapable of conducting my law practice in a competent manner. Such determination of incapacity shall be made by me or written certification by:

(i) a physician duly licensed to practice medicine who has treated me within one year preceding the date of such certification [*or consider two physicians*],

OR

(ii) my Agent, who shall base his findings on reliable sources, including one or more members of my immediate family, a written opinion of one or more licensed physicians who diagnosed or treated me within one year preceding the date of my incapacity, my law firm colleagues and/or my office staff with whom I maintained a close and continuous relationship during the period immediately preceding my incapacity,

OR

(iii) [name and address of other person(s) and statement of conditions, if any.]

As part of the process of determining whether I lack decision-making capacity, all individually identifiable health information and medical records may be released to my Agent even though such representative's appointment has not yet become effective [*or, if the principal/attorney has selected a person other than the Agent to make the determination of incapacity, insert such other person's name*]. This release and authorization applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320d and 45 C.F.R. § 160-164.<sup>2</sup>

I hereby appoint my Agent, for the sole and limited purpose and in my name and stead, of conducting all matters and managing all property, whether real or personal, that are related to or associated with my law practice in any way wherein I myself might act if I personally were

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2. To assure compliance with HIPAA, the principal/attorney, upon execution of this power of attorney, should sign two written authorizations, one to his or her health care provider, and one leaving the provider line blank, giving the identity of the person who will be making the decision that the principal/attorney is incapable of conducting his or her law practice (e.g., agent/attorney or family member). A sample authorization is attached to the end of this document.

present and to the extent that I am permitted by law to act through such an agent. These powers shall include, but shall not be limited to, the following:<sup>3</sup>

- a. **Access to my Office.** To enter my office, take possession, custody and control of all my office property, real and personal, including client files, office equipment, supplies, and records and to use such property to manage and/or close my law practice;
- b. **Designation as Signatory on Financial Accounts.** To replace me as signatory on all my law office accounts with any bank or financial institution, including without limitation attorney trust, escrow or special accounts and checking or savings accounts, and my banks or financial institutions may rely upon this authorization unless they have or acquire actual knowledge that this instrument has been revoked or is no longer in effect;
- c. **Opening of Mail.** To receive, sign for and open my law practice mail and deliveries whether by courier or otherwise, and to process and respond to them as appropriate;
- d. **Access To and Inventory/Examination of Files.** To enter any storage location where I maintain my files (whether in my office or off site); to inventory and examine all my client case files, property and records and, should (s)he identify a conflict of interest with a specific file or client, to assign such file upon client consent to my successor Agent named herein or to such other attorney as my Agent may deem appropriate;
- e. **Notification to Clients.** To notify my clients, potential clients and those who appear to be my clients, of my disability, incapacity or other inability to act, and to take whatever action (s)he may deem appropriate to protect the interests of such persons and entities, including advising them to obtain substitute counsel;
- f. **Transfer of Files.** To safeguard and return my clients' files upon request or as otherwise may be appropriate, or in the alternative to obtain consent from them to transfer their files to new counsel, all upon the acquisition of receipts therefore;
- g. **Storage of Files and Attorney's records.** To arrange for the storage of such of my closed and unclaimed files and records as must be preserved for seven years pursuant to the provisions of Disciplinary Rule 9-102(d) of The Lawyer's Code of Professional Responsibility;
- h. **Transfer of Property and Original Documents.** To transfer to my clients where appropriate, or to their designees, all their property and original documents, including wills, trusts and deeds;
- i. **Access to Safe Deposit Box.** To open my safe deposit box used for my law practice and located at \_\_\_\_\_, to inventory same, and to arrange for return of property to clients.
- j. **Notification to Courts and Others.** To advise all appropriate courts, agencies, opposing and other counsel, professional membership organizations such as the New York State Bar Association or local bar associations, the Office of Court Administration, and other appropriate individuals or entities, of my inability to act and of my Agent's authority to act in my behalf;

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3. *PLEASE NOTE THAT THE POWERS DESCRIBED IN THIS MODEL POWER OF ATTORNEY ARE BROAD AND SHOULD BE TAILORED TO THE SPECIFIC SITUATION AT HAND.*

k. **Extensions of Time.** To obtain consent from my clients for extensions of time, to contact opposing counsel and courts/administrative agencies to obtain extensions of time, and to apply for such extensions if necessary pending my clients' retention of new counsel;

l. **Litigation.** To file pleadings, motions and other documents, to appear before courts, administrative offices and agencies, and to take any and all other steps necessary to protect my clients' interests until their retention of other counsel;

m. **Collection of Fees and Return of Client Funds.** To dispatch invoices for my unbilled work; to collect fees and accounts receivable on my behalf; to prepare accountings for clients on retainer; to return client funds where appropriate; to prepare an accounting of each of my client's escrow funds and arrange for transfer of escrow funds, including the obtaining of consent from my clients to the transfer of such funds to new counsel or to my clients as appropriate;

n. **Payment of Business Expenses and Creditors.** To pay my business expenses, including office rent, rent for any leased equipment, library expenses, salaries to employees or other personnel; to determine the nature and amount of all claims of creditors, including my clients; and to pay or settle all such claims or accounts;

o. **Personnel.** To continue to employ such of my office staff as may be necessary to assist my Agent in the performance of his duties and to compensate them therefore; to terminate such employees or other personnel; and to employ such assistants, agents, accountants, attorneys or others as may be appropriate;

p. **Termination of Obligations.** To terminate or cancel my business obligations, including office and equipment leases, subscriptions and otherwise;

q. **Insurance.** To purchase, renew, maintain, cancel, make claims against or collect benefits under fire, casualty, professional liability insurance, or my other office insurance; to notify as appropriate all professional liability insurance carriers of my disability, incapacity or other inability to act; and to cooperate with such insurance carriers regarding matters related to my coverage, including the addition of my Agent as an insured under any such policies;

r. **Taxes.** To prepare, execute and file income, information or other tax returns, reports or other forms and to act on my behalf in dealing with the Internal Revenue Service, the New York State Department of Taxation and Finance, or any other federal, state and local tax departments, agencies or authorities;

s. **Disposition of Debts and Claims.** To prosecute, settle, defend, compromise, or submit to arbitration or mediation all debts, taxes, accounts, claims, or disputes involving my law practice and any other person or entity;

t. **Attorney as Fiduciary.** To resign any position which I hold as a fiduciary and to notify all other affected fiduciaries and beneficiaries thereof, and wherever appropriate to apply to any court of competent jurisdiction for the appointment of a successor fiduciary; and to account for the assets, income and disbursements attendant upon each such resigned fiduciary appointment;

u. **Power of Sale and Disposition.** To sell or otherwise arrange for the sale or other disposition of my office furniture, books or other office property.

v. **Representation of my Clients.** To provide legal services to my clients, provided that my agent has no conflict of interest, obtains the consent of my clients, and does not engage

in conduct that violates Disciplinary Rule 2-103 of The Lawyer's Code of Professional Responsibility. If my clients engage my Agent to perform legal services, my Agent shall have the right to payment for such services from such clients.

I hereby reserve the right to revoke this Limited Power of Attorney by written instrument, which shall not affect the validity of any actions taken by my Agent prior to such revocation.

To induce third parties to act hereunder, I hereby agree that any such third party receiving a duly executed original copy of this instrument, or a copy certified in such manner as to make it viable and effective as provided by law, may act hereunder, and that the revocation or termination of this instrument shall be ineffective as to any such third party unless and until such third party's knowledge or receipt of notice of such revocation or termination, and I, for myself, my heirs, executors, administrators, legal representatives, successors and assigns hereby agree to indemnify and hold harmless any such third party against any claim(s) that may arise against such third party by reason of his or her having so relied upon the provisions of this instrument.

If \_\_\_\_\_ (name of Agent) is unable or unwilling to serve as my Agent hereunder, or no longer practices law, I hereby appoint \_\_\_\_\_, an attorney licensed and in good standing to practice law in the State of New York, residing at \_\_\_\_\_, and with offices located at \_\_\_\_\_, to be my Agent for the limited purposes set forth herein,

This Limited Power of Attorney shall not be affected by my subsequent disability or incapacity, and shall be governed in all respects by the laws of the State of New York.

\_\_\_\_\_  
(Name of Principal)

STATE OF NEW YORK     )  
  )ss.:  
COUNTY OF                     )

On this day of , 200\_\_, before me, the undersigned, a notary public in and for said state, personally appeared \_\_\_\_\_, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument, who acknowledged to me that (s)he executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of whom the individual acted, executed the instrument.

\_\_\_\_\_  
Notary Public

**GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR  
DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**PATIENT NAME:**

\_\_\_\_\_

**ADDRESS:**

\_\_\_\_\_

**SOCIAL SECURITY NUMBER:**

\_\_\_\_\_

**I AUTHORIZE THE CUSTODIAN OF THE RECORDS \_\_\_\_\_ TO  
DISCLOSE/RELEASE THE FOLLOWING INFORMATION \_\_\_\_\_ [ALL MEDICAL  
RECORDS, INCLUDING MENTAL HEALTH, SUBSTANCE ABUSE AND HIV/AIDS RECORDS] OR [A  
SUBSET OF RECORDS]. THESE RECORDS ARE FOR SERVICES RENDERED [IN THE LAST TWO  
YEARS] OR: \_\_\_\_\_.**

**PLEASE SEND THE RECORDS LISTED ABOVE TO [AGENT]**

**NAME:**

\_\_\_\_\_

**ADDRESS:**

\_\_\_\_\_

**PHONE NUMBER:**

\_\_\_\_\_

**THE INFORMATION MAY BE USED/DISCLOSED TO ASSIST IN THE DETERMINATION OF MY  
MENTAL OR PHYSICAL CAPACITY TO PRACTICE LAW.**

**THE AUTHORIZATION EXPIRES ONE (1) YEAR FROM THE DATE IT IS PRESENTED TO THE  
CUSTODIAN OF RECORDS.**

**I UNDERSTAND THAT AFTER THE CUSTODIAN OF RECORDS DISCLOSES MY HEALTH  
INFORMATION, IT MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY LAWS. BY SIGNING  
BELOW I REPRESENT AND WARRANT THAT I HAVE AUTHORITY TO SIGN THIS DOCUMENT AND  
AUTHORIZE THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AND THAT THERE  
ARE NO CLAIMS OR ORDERS PENDING OR IN EFFECT THAT WOULD PROHIBIT, LIMIT OR  
OTHERWISE RESTRICT MY ABILITY TO AUTHORIZE THE USE OR DISCLOSURE OF THIS  
PROTECTED HEALTH INFORMATION.**

\_\_\_\_\_  
**SIGNATURE OF PATIENT**

\_\_\_\_\_  
**DATE**