APPENDIX E

HEALTH CARE PROXY AND LIVING WILL*

TO MY FAMILY, MY DOCTORS, MY HEALTH CARE AGENT AND OTHERS CONCERNED WITH MY CARE:

A. HEALTH CARE PROXY

I, [name], residing at [address], am making this declaration while in full possession of my faculties, and after long and careful consideration.

I hereby appoint [name], residing at [address], telephone [number], as my health care agent to accept, refuse or make health care decisions about my treatment and hospitalization in accordance with my wishes and instructions as stated herein or as otherwise known to him/her in the event that I am unable to make such decisions myself. In the event that [name] is unable, unwilling or unavailable to act as my health care agent, I hereby appoint [name] residing at [address], telephone [number], as my alternate health care agent to make such health care decisions in the event that I am unable to make such decisions myself.

I intend for my health care 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 information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 1320d and 45 C.F.R. pts.160-164. 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 clearing house 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 agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition of every nature and kind. The authority given to my health care 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.

I understand that unless I revoke it, this Health Care Proxy shall remain in effect indefinitely. It is my direction that my health care agent act in accordance with my wishes set forth below in my Living Will.

B. LIVING WILL

I, [name], residing at [address], am making this declaration while in full possession of my faculties, and after long and careful consideration.

I do not wish to be kept alive by various measures if there is no reasonable expectation of my being able to enjoy a meaningful quality of life due to my medical condition.

Accordingly, I direct that life-sustaining procedures should be either withheld or withdrawn if I have an illness, disease or injury, or experience extreme mental deterioration, and if doctors selected by me or by my family determine that there is no reasonable expectation that I will recover to a sufficient extent to enable me to enjoy a meaningful quality of life. It is obviously impossible to foresee all of the

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