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Official Record
Recording requested By
EDDIE S. GIAMPAPA
Lincoln County - NV
Leslie Boucher - Recorder
Fee: $18.00 Page 1 of 5
RPTT: Recorded By: AE
Book- 258 Page- 0604

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APN_____

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HEALTH DURABLE POWER OF ATTORNEY

Title of Document

Affirmation Statement

✓ I, the undersigned hereby affirm that the attached document, including any exhibits, hereby submitted for recording **does not contain** the social security number of any person or persons. (Per NRS 239B.030)

_____ I, the undersigned hereby affirm that the attached document, including any exhibits, hereby submitted for recording **does contain** the social security number of a person or persons as required by law: _____
(State specific law)

Eddie Giampapa
Signature Title

EDDIE GIAMPAPA
Print

OCT 7 2010
Date

Grantees address and mail tax statement:

PO Box 431
PANACA NV
89042

STATE OF NEVADA DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

DISCLOSURES

I, EDDIE S. GIAMPAPA, of 207 North Hollingshead Street, Panaca Nevada 89042, understand that this DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS is an important legal document, and I further understand and disclose the following:

1. This document gives the person I designate as my agent the power to make health care decisions for me. This power is subject to any limitations or statements of my desires that I include in this document. The power to make health care decisions for me may include consent, refusal of consent or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition.
2. The person I designate as my agent has a duty to act consistently with my desires as stated in this document, or with my desires that I have otherwise made known to my agent, or if my desires are unknown, to act in my best interests.
3. Except as I otherwise specify in this document, the power of the person I designate to make health care decisions for me may include the power to communicate with my doctor to stop giving me treatment which could keep me alive.
4. I understand that the power granted in this document will exist indefinitely from the date I execute it, and If I am unable to make health care decisions for myself, this power will continue until the time when I become able to make health care decisions for myself or until I die.
5. Notwithstanding this document, I have the right to make medical and other health care decisions for myself, so long as I can give informed consent with respect to the particular decision. In addition, no treatment may be given to me over my objection, and health care necessary to keep me alive may not be stopped if I object.
6. I have the right to revoke this document, either in all or in part, or to revoke the appointment of the person I have designated as my agent to make medical and/ or health care decisions for me, by notifying that person either orally or in writing.
7. I have the right to revoke this document, either in all or in part, or to revoke the appointment of the person I have designated as my agent to make medical and/ or health care decisions for me, by notifying the treating physician, hospital or other provider of health care, either orally or in writing.
8. I understand that the person I have designated as my agent to make medical and/ or health care decisions for me has the right to examine my medical records and to consent to their disclosure unless I limit this right in this document.
9. This document revokes any prior DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS I may have executed, recorded or otherwise created.

IN WITNESS WHEREOF I have hereunto set my hand this

7 day of OCT, 2010

Eddie S. Giampapa

EDDIE S. GIAMPAPA

DESIGNATION OF HEALTH CARE AGENT

I, EDDIE S. GIAMPAPA, of 207 North Hollingshead Street, Panaca Nevada 89042, do hereby designate and appoint:

Name: EDDIE RANDALL GIAMPAPA.
Address: 1815 Paul Lane, Concord California 94521
Telephone Number: (925) 609-7301

as my agent to make health care decisions for me as authorized in this document.

CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

GENERAL STATEMENT OF AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the agent named above full power and authority: to make health care decisions for me before or after my death, including consent, refusal of consent or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition; to request, review and receive any information, verbal or written, regarding my physical or mental health, including, without limitation, medical and hospital records; to execute on my behalf any releases or other documents that may be required to obtain medical care and/or medical and hospital records, EXCEPT any power to enter into any arbitration agreements or execute any arbitration clauses in connection with admission to any health care facility including any skilled nursing facility; and subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

SPECIAL PROVISIONS AND LIMITATIONS

In exercising the authority under this durable power of attorney for health care, the authority of my agent is subject to the special provisions and limitations listed below:

_____

_____

_____

_____

_____

By law, my agent is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization or abortion.

E S G

I understand that if I you do not write any limitations, my agent will have the broad powers to make health care decisions on my behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.

DURATION

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent will continue to exist until the time when I become able to make health care decisions for myself.

I wish to have this power of attorney end on the following date: _____. If no date is indicated, this power of attorney will exist indefinitely.

STATEMENT OF DESIRES

With respect to decisions to withhold or withdraw life-sustaining treatment, my agent is required to make decisions consistent with my Living Will or Directive to Physicians regarding Life-Sustaining Treatment.

DESIGNATION OF ALTERNATE AGENT

If the person designated in paragraph 1 as my agent is unable to make health care decisions for me, then I designate the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. Alternative Agent

Name: EDDIE ROBERT GIAMBRONE

Address: 9049 PINE MISSION AVE LV NV 89143

Telephone Number: 702-338-6566

PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care.

WAIVER OF CONFLICT OF INTEREST

If my designated agent is my spouse or is one of my children, then I waive any conflict of interest in carrying out the provisions of this Durable Power of Attorney for Health Care that said spouse or child may have by reason of the fact that he or she may be a beneficiary of my estate.

CHALLENGES

If the legality of any provision of this Durable Power of Attorney for Health Care is questioned by my physician, my agent or a third party, then my agent is authorized to commence an action for declaratory judgment as to the legality of the provision in question. The cost of any such action is to be paid from my estate. This Durable Power of Attorney for Health Care must be construed and interpreted in accordance with the laws of the State of Nevada.

E. R. G.

NOMINATION OF GUARDIAN

If, after execution of this Durable Power of Attorney for Health Care, incompetency proceedings are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court my agent herein named, in the order named.

RELEASE OF INFORMATION.

I agree to, authorize and allow full release of information by any government agency, medical provider, business, creditor or third party who may have information pertaining to my health care, to my agent named herein, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended, and applicable regulations.

IN WITNESS WHEREOF I have hereunto set my hand this

7 day of OCT, 2010

Eddie S. Giampapa

EDDIE S. GIAMPAPA

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF NEVADA)

)ss.

COUNTY OF LINCOLN)

On this 7th day of October, 2010, before me M. HOWARD (name of the notary public) personally appeared EDDIE S. GIAMPAPA, whose name is subscribed to this instrument as party thereto, personally known to me to be the same person described in and who executed the said instrument as party thereto, and duly acknowledged to me that the foregoing instrument was executed as his free act and deed and which was done voluntarily, and for the use and purposes therein mentioned.

NOTARY SEAL

M. HOWARD
NOTARY PUBLIC-STATE of NEVADA
Lincoln County • Nevada
CERTIFICATE # 06-5506-11
APPT. EXP. December 10, 2011

M Howard

Notary Public