MEDICAL POWER OF ATTORNEY

IMPORTANT INFORMATION

IT IS IMPORTANT THAT YOU REVIEW THE FOLLOWING INFORMATION BEFORE YOU SIGN THIS DOCUMENT. READ THE INFORMATION CAREFULLY AND SEEK GUIDANCE FROM A HEALTHCARE PROFESSIONAL OR ATTORNEY IF YOU DO NOT UNDERSTAND ANY OF THE TERMS.

By signing this document, you are giving authority to the person you are designating as your Agent to make medical decisions on your behalf. Medical decisions can include any medical service, treatment, medical procedure, diagnosis or treat both mental and physical conditions. Your Agent will be able to act with the same authority you would have if you were able to act for yourself and will have the authority to consent and refuse to consent to medical treatment **including decisions about withdrawing or withholding life-sustaining treatment**. It is, therefore, important that you know and trust your agent and that your agent is aware of your preferences for health care treatment.

Even after you sign this document, you will still be able to make your health care decisions assuming you are still considered mentally competent. Your agent cannot act on your behalf until your physician has determined that you are no longer physically or mentally able to make medical decisions unless otherwise stated in this document.

The person you choose as your agent must be at least eighteen years old and someone that you trust with your health care. Your agent is not liable for any decisions they make on your behalf, as long as those decisions were made in good faith. You should make sure that you have chosen an agent that wants to take on the role of the agent. Discuss your medical preferences with your agent so they are aware of your wishes. Review this document with your agent so they are aware of their role. You also may choose up to two (2) Alternate Agents in case your main Agent is unavailable to act. Your Alternate Agent(s) should also be over 18 and aware of your preferences.

You may revoke this document at any time while you are still competent to do so. You may revoke it by telling your medical provider and your agent that you are revoking the document or you may provide them a written revocation (Recommended). If you execute another power of attorney later, that will have the effect of revoking this one.

In order for this document to be valid, it must be signed in the presence of a notary or two (2) witnesses. If you choose to have two witnesses sign, they must be at least 18, competent and independent and not your agent or related to your agent.

PART I. APPOINTMENT OF HEALTH CARE AGENT

I, Claudia Margarita Sanchez de Yruegas, of 11800 Scott Simpson, El Paso, Texas, 79936 (hereinafter known as the “Principal”) hereby appoint, Wendy Angelica Garcia, of 4101 Central Ave, Apt. 4020, Albuquerque, New Mexico, 87108 (hereinafter known as the “Agent”) as my Agent to make any and

all medical decisions on my behalf, except to the extent that I limit in this document. My Agent can be reached at the following contact information:

Home Phone: N/A **Work Phone**: N/A

Cell Phone: (575) 496-0764 **E-Mail**: N/A

APPOINTMENT OF ALTERNATE AGENT(S)

If my Agent appointed above is unable or unwilling to serve, I appoint the following person(s) to serve as Agent(s) in the order set forth below with the authority to make health care decisions on my behalf as provided herein:

1st Alternate Agent

Lesley Garcia of 1894 Trulyn Ave, Manteca, California, 95337 can be best reached at the following phone number: (915) 820-8874.

If my main Agent, Wendy Angelica Garcia, and the 1st Alternate Agent, Lesley Garcia, are unable or unwilling to serve, there shall be no other individuals authorized to make medical decisions on my behalf.

LIMITATIONS OF MY AGENT

Initial

_____ - AGENT'S AUTHORITY: shall not have any limitations to the medical decision making powers they may make on my behalf. Therefore I acknowledge that the Agent shall have the right to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive.

_____ - I intend for my agent to be treated as I would with respect to my rights regarding the use and disclosure of my individually identifiable health information or medical records. This release authority applies to information governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 USC 1320d, 45 CFR 160-164.

DURATION

Unless stated otherwise herein, this document shall remain in effect until I revoke it. I understand that I cannot revoke this document during the time I am considered incompetent to make my own decisions.

Initial

_____ - This document shall not have an end date and shall terminate upon revocation, a new medical power of attorney, or my death.

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE

My Agent's authority becomes effective (Initial Below) when:

Initial

_____ - My primary physician determines that I am unable to make my own health care decisions.

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 II 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.

AGENT'S POST DEATH AUTHORITY

Initial

_____ - My Agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form with no exceptions.

PRIOR MEDICAL POWER OF ATTORNEY

By signing this document, I hereby revoke any and all prior medical powers of attorney that I may have executed.

PART II. LIVING WILL

Initial

_____ - I, Claudia Margarita Sanchez de Yruegas, declare to include this Living Will as part of my Medical Power of Attorney Form.

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 initialed below:

Initial

_____ - I choose not to prolong life if I have an incurable and irreversible condition that will result in my death within a relatively short time, or if I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or the likely risks and burdens of treatment would outweigh the expected benefits.

RELIEF FROM PAIN

Initial

_____ - In regards to pain, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

OTHER WISHES

Initial

_____ - I would like to add the following: Do not resuscitate.

PART III. DONATION OF ORGANS

Initial

_____ - I wish to donate the any and all organs, parts, or tissues.

PART IV. PRIMARY CARE PHYSICIAN

I, Claudia Margarita Sanchez de Yruegas, wish to enter my Primary Care Physician's information as detailed below:

Primary Care Physician: Celina Beltran with an office location of 8061 Alameda Ave. , El Paso, Texas, 79915 **Telephone**: (915) 859-7545

ORIGINAL AND COPIES OF THIS DOCUMENT

This original document and/or copies shall be kept at the following locations: Family Members : Lesley Garcia & Wendy Angelica Garcia

GOVERNING LAW

This document shall be governed by the laws of the State of Texas.

EXECUTION

You must initial, date, and sign this power of attorney before a notary public or two (2) witnesses not related by blood or marriage.

Principal's Signature _____
Claudia Margarita Sanchez de Yruegas

NOTARY ACKNOWLEDGMENT

STATE OF _____

_____ County, ss.

The undersigned, being a Notary Public certified in _____, declares that, Claudia Margarita Sanchez de Yruegas, making this Durable Health Care Power of Attorney has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to Claudia Margarita Sanchez de Yruegas by blood, marriage, or adoption, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing health care to the person signing. I am not entitled to any part of his/her estate under a will now existing or by operation of law. In the event the person acknowledging this Durable Health Care Power of Attorney is physically unable to sign or mark this document, I verify that he/she directly indicated to me that this Durable Health Care Power of Attorney expresses his/her wishes and that he she intends to adopt the Durable Health Care Power of Attorney at this time.

WITNESS MY HAND AND SEAL this ___ day of _____, 20___

_____
Notary Public

Print Name: _____

My Commission Expires: _____

WITNESS STATEMENT AND ACKNOWLEDGMENT

I am not the person appointed as agent or successor agent in this medical power of attorney. I am not related to Claudia Margarita Sanchez de Yruegas by blood or marriage. I am not entitled to any portion of the Claudia Margarita Sanchez de Yruegas's estate, nor do I have any claim against their estate. I am not the attending physician of Claudia Margarita Sanchez de Yruegas or an employee of the attending physician. I am not involved in providing direct patient care to Claudia Margarita Sanchez de Yruegas and not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the healthcare facility.

SIGNATURE OF THE FIRST WITNESS

Signature: _____

Print Name: _____ Date: _____

Address: _____

SIGNATURE OF THE SECOND WITNESS

Signature: _____

Print Name: ___________________________________ Date: __________

Address: ____