

NOT AN OFFICIAL DOCUMENT

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, Linda D. Ashford, of 900 E. 53rd Avenue, Merrillville, Indiana, being of sound mind, voluntarily create this Durable Power of Attorney for Health Care.

PRIOR DESIGNATIONS

I revoke any prior Durable Power of Attorney for Health Care.

APPOINTMENT OF HEALTH CARE ATTORNEY-IN-FACT

In the event that I have been determined to be incapable of providing informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my attorney-in-fact for health care decisions:

Paula S. Rogers
900 E. 53rd Avenue
Merrillville, Indiana 46410
Telephone: (219) 334-6415
Relationship: Daughter

ATTORNEY-IN-FACT'S AUTHORITY

My attorney-in-fact is authorized to act for me in all matters relating to my health care. My attorney-in-fact's powers include, but are not limited to:

- Full power to consent, refuse consent, or withdraw consent to all medical, surgical, hospital and related health care treatments and procedures on my behalf, according to my wishes as stated in this document, or as stated in a separate Living Will, Health Care Directive, or other similar type document, or as expressed to my attorney-in-fact by me;
- Full power to make decisions on whether to provide, withhold, or withdraw artificial nutrition and hydration on my behalf, according to my wishes as stated in this document, or as stated in a separate Living Will, Health Care Directive, or other similar type document, or as expressed to my attorney-in-fact by me;
- Full power to review and receive any information regarding my physical or mental health, including medical and hospital records, in accordance with the *Health Insurance Portability and Accountability Act of 1996*, 42 USC 1320d ("HIPAA"), and the *American Recovery and Reinvestment Act of 2009* ("ARRA");

GINA PIMENTEL
RECORDER
STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

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- Full power to sign any releases in order to obtain this information;
- Full power to sign any documents required to request, withdraw, or refuse treatment or to be released or transferred to another medical facility.

My attorney-in-fact does not have authority to act for me for any other purpose unrelated to my health care. All of my attorney-in-fact's actions under this power during any period when I am unable to make or communicate health care decisions have the same effect on my heirs, devisees and personal representatives as if I were competent and acting for myself.

WHEN ATTORNEY-IN-FACT'S AUTHORITY BECOMES EFFECTIVE

The designation of my attorney-in-fact will become effective as soon as this document is signed and will remain in effect until my death, or until I revoke it. This designation will not be affected by my subsequent disability or incompetence.

ATTORNEY-IN-FACT'S OBLIGATIONS

My attorney-in-fact will make health care decisions for me in accordance with this document, and in accordance with any instructions I give in a Living Will, Health Care Directive or other such document (either included in this document or as a separate document), and my other wishes to the extent known to my attorney-in-fact. To the extent my wishes are unknown, my attorney-in-fact will make health care decisions for me in accordance with what my attorney-in-fact determines to be in my best interest. In determining my best interest, my attorney-in-fact will consider my personal values to the extent known to my attorney-in-fact.

EFFECT OF COPY

A copy of this Durable Power of Attorney for Health Care has the same effect as the original.

SEVERABILITY

If any part or parts of this Durable Power of Attorney for Health Care is found to be invalid or illegal under applicable law by a court of competent jurisdiction, the invalidity or illegality of such part or parts shall not in any way affect the remaining parts, and this document shall be construed as though the invalid or illegal part or parts had never been included herein. But if the intent of this Durable Power of Attorney for Health Care would be defeated by such construction, then it shall not be so construed.

ACKNOWLEDGMENT AND SIGNATURE

I authorize my agent (attorney-in-fact) to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my agent is satisfied that certain health care is not or would not be beneficial or

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that such health care is or would be excessively burdensome, then my agent may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My agent must try to discuss this decision with me. However, if I am unable to communicate, my agent may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my agent may also discuss this decision with my family and others to the extent they are available.

Executed this 23rd day of March, 2021

Signature: Linda D. Ashford

Name: Linda D. Ashford
Address: 900 E. 53rd Avenue, Merrillville, Indiana 46410

NOTARIZATION

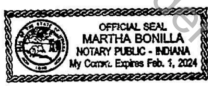
"I AFFIRM, UNDER THE PENALTIES FOR PERJURY THAT I HAVE TAKEN REASONABLE CARE TO REDACT EACH SOCIAL SECURITY NUMBER IN THIS DOCUMENT, UNLESS REQUIRED BY LAW."
PREPARED BY: J.R.R.

STATE OF INDIANA
COUNTY OF Porter

Before me, a Notary Public for Porter County, State of Indiana, personally appeared Linda D. Ashford, and acknowledged the execution of this instrument this 23rd day of March, 2021.

Martha Bonilla
Notary Public

Martha Bonilla
(print name)



My commission expires: Feb 1, 2024

Prepared by: Paula S. Rogers
Paula S. Rogers