

APN# _____

Recording Requested by/Mail to:

Name: Juanita Gaghagen

Address: PO Box 213

City/State/Zip: Gardonsville NV 89410

Mail Tax Statements to:

Name: _____

Address: _____

City/State/Zip: _____



00045794201608902530080083

KAREN ELLISON, RECORDER

Power of attorney
Title of Document (required)

----- (Only use if applicable) -----

The undersigned hereby affirms that the document submitted for recording contains personal information as required by law: (check applicable)

Affidavit of Death – NRS 440.380(1)(A) & NRS 40.525(5)

Judgment – NRS 17.150(4)

Military Discharge – NRS 419.020(2)

Signature

Printed Name

This document is being (re-)recorded to correct document # _____, and is correcting

NEVADA DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS FOR JUANITA G. GAGHAGEN

WARNING: THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR ATTORNEY-IN-FACT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENT OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU 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. YOU MAY STATE IN THIS DOCUMENT TREATMENT OR PLACEMENTS THAT YOU DO NOT DESIRE.
2. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.
3. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THE POWER OF THE PERSON YOU DESIGNATE TO MAKE HEALTH CARE DECISIONS FOR YOU INCLUDES THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT WHICH WOULD KEEP YOU ALIVE.
4. UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST INDEFINITELY FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOU.
5. NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION. HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED IF YOU OBJECT.
6. YOU HAVE THE RIGHT TO REVOKE THE APPOINTMENT OF THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THAT PERSON OF THE REVOCATION ORALLY OR IN WRITING.
7. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY GRANTED TO THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS

FOR YOU BY NOTIFYING THE TREATING PHYSICIAN, HOSPITAL, OR OTHER PROVIDER OF HEALTH CARE IN WRITING.

8. THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT HEREIN.

9. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DON'T UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

1. DESIGNATION OF HEALTH CARE AGENT.

I, **Juanitia G. Gaghagen**, residing in Nevada, do now hereby authorize you to release, disclose and deliver medical data and allow for any and all medical decisions described below regarding myself to my daughter, **Susette L. Gaghagen**, as my medical attorney in fact. She is to act on my best behalf, in my stead and in my place in all medical matters now and any time I require assistance or complete health care management, so he will manage my own medical matters and health care decisions. I authorize you to release, disclose and deliver medical data to **Susette L. Gaghagen**, all of my medical data, records, documents, and medical decisions, as authorized herein, including signing and executing instruments and papers for my medical and other health care decisions and authorizations.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney, appointing **Susette L. Gaghagen**, who shall make when necessary if I am disabled, my health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. 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 attorney-in-fact, **Susette L. Gaghagen**, the 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, subject only to the limitations and special provisions, if any.

4. SPECIAL PROVISIONS AND LIMITATIONS.

In exercising the authority under this durable power of attorney for health care, the authority of my attorney-in-fact is subject to the following special provisions and limitations: No Limits.

5. DURATION. I understand that this power of attorney will exist indefinitely from the date I execute this document unless noted otherwise. I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

6. STATEMENT OF DESIRES.

I authorize you to release, disclose, and deliver all my medical data to **Susette L. Gaghagen**

(With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.) (If the statement reflects your desires, initial the box next to the statement.)

1. **I desire that my life be prolonged to the greatest extent possible**, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures. [J.S.]

2. If I am in a coma which is diagnosed by two (2) licensed official physicians' reports, and they have reasonably concluded it is irreversible, then I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this Subparagraph is initialed.) [J.S.]

3. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, diagnosed by two (2) licensed official physicians' reports, then I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.) [J.S.]

4. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld. [J.S.]

5. I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life. [J.S.]

6. Burial } Cremation [J.S.]

7. PRIOR DESIGNATIONS REVOKED.

I, Juanitia G. Gaghagen, do hereby revoke any prior durable power of attorney for health care. Now as Principal, I, Juanitia G. Gaghagen, do sign my name and execute this Durable Power of Attorney for Health Care on July 19, 2016, in Nevada.

AUGUST

I declare that I am of sound mind, and that I am not under duress or coercion, that I am not under any undue influence, and without fraud. I appoint and name Jayne Peters and/or Janet Howard, as my attorney in facts for health care medical decisions, data, documents, records, and management for me, now to assist me or act fully for me, by which I am granting Susette L. Gaghagen, my daughter, as my agent, as my power of attorney, my attorney in fact and my Personal Representative for me.

I do not want to live in nursing home.

Juanita G. Gaghagen
Juanitia G. Gaghagen, Principal

State of Nevada)
)s.s.
County of Carson)

Sworn and subscribed to before me, Notary Public for Nevada, Carson County, on July 19, 2016, personally appearing properly identified, Juanitia G. Gaghagen, Principal, who signed this document of her own free will, act and deed.

August
AUGUST

Notary Public [Signature]



DEBORAH G. SUMNER
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 04-02-19
Certificate No: 99-55313-3

DURABLE POWER of ATTORNEY for FINANCES for Juanitia G. Gaghagen

KNOW ALL MEN BY THESE PRESENTS, that I, Juanitia G. Gaghagen, living in Nevada, do hereby now declare myself being of sound mind and clear judgment, do hereby authorize you to release, disclose, deliver, and allow for all financial decisions named below of any and all types of financial transactions and matters to be managed, handled and executed by my attorney in facts, appointed and named now by myself shall be my daughter, Susette L. Gaghagen, to assist me or manage for me as needed, immediately, as my appointed agent and my attorney-in-fact, who is my appointed Personal Representative, Executor and Successor Trustee. Susette L. Gaghagen has shall be my chosen power of attorney in facts for all of my financial decisions, data, and matters regarding myself and my estate, my true and lawful attorney for me and in my name, place and stead, on my behalf, for my use and benefit, to sign and execute in my place, as stated herein. She and I are Trustees in my Nevada Trust dated July 19, 2016.

1. To exercise or perform any act, power, duty, right or obligation whatsoever that I now have, or may hereafter acquire the legal right, power, or capacity to exercise or perform, in connection with, arising from, or relating to any person, item, transaction, thing, business, property, real or personal, tangible or intangible, including but not limited to: Bank of the West, Eldorado Savings Bank, my home located in Wellington, Nevada and my property located in South Lake Tahoe California, my vehicles, bank accounts and investments.

2. To request, ask, demand, sue for, recover, collect, receive, and hold, possess and invest all sums of money, debts, commercial paper, checks, drafts, accounts, deposits, bequests, devises, notes, interests, bonds, dividends, certificates of deposit, any and all documents of title, chooses in action, and demands whatsoever, whether agreed to or disputed, as now are, or shall hereafter become, owned by, or due, owing payable, or belonging to, me or in which I have or May hereafter acquire any interest, to have, or use; and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof, and to adjust, sell, compromise, and agree for the same; and to make, execute, and deliver for me, on my behalf, in my name, all endorsements, releases, receipts, discharges for same as if done by me.

3. To maintain, repair, improve, manage, insure, rent, lease, grant, bargain, sell, exchange, pledge and contract for all of the foregoing, and in any way or manner deal with all or any part of any real or personal property whatsoever, tangible or intangible, or any interest therein, that I now own or may hereafter acquire, in my behalf, and in my name; and to effect any or all of the above-described transactions to any entities on such terms and at prices my attorney-in-facts may deem proper, and in my name to make, execute, acknowledge and deliver any deed of conveyance or other instrument, necessary to effect such transactions; and to ask for, demand, sue for, collect, recover and receive all monies which may become due and owing to me.

4. To conduct, engage in, and transact, to receive, deposit, hold, or cash all payments which I receive from Social Security, Medicare or other government program or agency, and proceeds and to request, ask, demand, sue for and recover same.

5. To enter any safe deposit box, bank account, or other storage area leased by me or in conjunction with any other person, to sign such documents as may be necessary to gain access to same, including but not limited to: Bank of America and U.S. Bank accounts, safety deposit boxes, monetary accounts, my property, land and home, and my vehicle.

6. To prepare, or cause to be prepared, federal, state and local tax returns and Internal Revenue Service, state and local powers of attorney; to execute and file federal, state and local tax returns on my behalf and in my name; to respond to notices and audit inquiries and to settle tax disputes.

7. I grant to said attorney-in-fact, my daughter, Susette L. Gagghagen, who is also Co- Trustee with me in my Nevada Trust, full power and authority to do, take, and perform, all and every act and thing whatsoever requisite, proper, or necessary to be done, in the exercise of any of the rights and powers herein granted, as fully for all intents and purposes as I might or could do if personally present, with full power of substitution or revocation, hereby ratifying and confirming all that said attorney, or substitute or substitutes, shall lawfully do or cause to be done by virtue of this power of attorney and the rights and powers herein granted.

8. If this Durable Power of Attorney is terminated by operation of law, any person acting in reliance upon it without notice of such termination shall be held harmless. The numbering of terms, rights, or powers is not intended to limit the definition or scope of powers granted herein.

9. I grant special power of attorney to my attorney in facts to sell my land, property and mobile home, and to sign and execute all sales and real estate documents on my behalf, in my name, place, and stead, for my benefit, as though it were myself present and signing/executing such.

10. IN WITNESS WHEREOF, I, Juanitia G. Gagghagen, have signed and executed this Durable Power of Attorney on July 19, 2016, in Nevada. Now I declare that I am of sound mind, and that I am not under duress or coercion, that I am not under any undue influence, and document is signed and executed by me of my own free will, act, and deed.

Dated July 19, 2016.
August

8/19/2016

Juanitia Gagghagen
Juanitia G. Gagghagen, Principal

State of Nevada)
)s.s.
County of Carson)

Sworn / subscribed to before me, Notary Public for Nevada, Carson County, on July 19, 2016, personally appearing identified, Juanitia G. Gagghagen, Principal, who signed this document of her own free will, act and deed.

August

Notary Public



DEBORAH G. SUMNER
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 04-02-19
Certificate No: 89-55313-3

MEDICAL HIPAA FEDERAL RELEASE - NAMED MEDICAL ATTORNEY IN FACT

To:

Re: **Juanitia G. Gaghagen, DOB:** 3, 5, 1978

1. I, Juanitia G. Gaghagen, of Nevada, do hereby authorize you to release, disclose and deliver medical data and medical decisions described below regarding myself to my daughter, Susette L. Gaghagen. You are authorized to release all medical data from your records on myself to her and this document may be revoked by the undersigned at any time by giving written notice to the party authorized herein, when I am unable to make medical decisions for myself due to severe accident, illness, surgery, or medical incapacity. Any disclosure made prior to revocation in reliance upon this authorization shall not constitute a breach of rights of confidentiality of the patient. This data expires in thirty (30) years from the date of signature.

2. The party named above to receive the data is not authorized to make any further release or disclosure of the data received. This authorization does not authorize the release or disclosure of any data except as provided herein. The following notice regarding redisclosure of substance (drug and alcohol) abuse data must be included with any such data disclosed pursuant to this authority, if such disclosure is authorized herein: This data has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this data unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. This POA general authorization for the release of medical or other data is NOT sufficient for this purpose. The Federal rules restrict any use of the data to criminally investigate or prosecute any alcohol or drug abuse patient. **This medical data may be released as provided in this authorization to Susette L. Gaghagen.** Now I, Juanitia G. Gaghagen, am signing this release without duress or undue influence, without coercion, with my competent mind, of my own free will, act and deed.

Dated July 19, 2016.
August

Juanitia G. Gaghagen
Juanitia G. Gaghagen, Principal

State of Nevada)
)s.s.
County of Carson)



DEBORAH G. SUMNER
NOTARY PUBLIC
STATE OF NEVADA
My Commission Expires: 04-02-19
Certificate No: 99-55313-3

Sworn and subscribed to before me, Notary Public for Nevada, Carson County, on July 19, 2016, personally appearing properly identified, Juanitia G. Gaghagen, who signed August this document of her own free will, act and deed.

[Signature]
Notary Public