CONDITIONAL DURABLE POWER OF ATTORNEY

STATE OF TENNESSEE  )
COUNTY OF KNOX    )

Know all men by these presents that I, [NAME OF ATTORNEY] do hereby make and appoint ______________________ my true and lawful Attorney-in-Fact for me in my name, place, and stead on behalf of me for my use and benefit upon the following terms and conditions and do hereby revoke all previous powers of attorney which I may have executed. THIS POWER OF ATTORNEY SHALL ONLY BECOME EFFECTIVE UPON MY INCAPACITY OR A DISABILITY THAT RENDERS ME INCAPABLE OF CONTINUING TO PRACTICE LAW.

I have executed an Authorization for Release of Medical Information on this same date as well which authorizes my health care providers to disclose to my Attorney-in-Fact any pertinent individually identifiable health information, including my protected health information which may be necessary to determine whether or not I am disabled or incapacitated so as to be no longer able to continue to practice law and to obtain a certification from a physician to that effect.

1. Authorization to Act. My Attorney-in-Fact is hereby authorized for me and in my name, place, and stead on my behalf and for my use and benefit to do all of the acts and activities required of a Receiver Attorney as described specifically in the Agreement Regarding Service As Receiver Attorney dated ________________, 2016.

2. Further Authority. I grant to said Attorney-in-Fact full power and authority to do, take, and perform all and every act and thing whatsoever required, proper, and necessary to be done, in the exercise of any of the rights and powers herein granted to the same extent that I could do if personally present with full power of substitution or revocation.

3. Ratification of Acts. I hereby ratify and confirm all and every act that my Attorney-in-Fact shall do or cause to be done by virtue of this appointment as Attorney-in-Fact and all documents of any kind executed or delivered by my Attorney-in-Fact shall bind me and my heirs, distributes, legal representatives, successors, and assigns.

4. Durable Power of Attorney. The rights, powers, and authority of my said Attorney-in-Fact granted in this document shall commence and be in full force and effect only upon my becoming incapacitated or disabled so as to be incapable of continuing to practice law, and remain effective only during such disability or incapacity on my part, whether or not the same shall be adjudicated in any court, it being my intent that the authorizations and powers granted in this document shall become effective and remain exercisable only during any such occurrence. Pursuant to Tenn. Code Ann. §§ 34-6-101 et seq., this Conditional Durable Power of Attorney, unless otherwise specifically rescinded or revoked by me, shall remain in full force and effect and shall not be revoked by operation of law in the event of such incompetence or incapacity.
5. **Inducement.** For the purpose of inducing any bank, broker, custodian, insurer, lender, transfer agent, or other party to act in accordance with the powers granted in this Conditional Durable Power of Attorney, I hereby represent, warrant, and agree that if this Conditional Durable Power of Attorney is terminated for any reason whatsoever, my heirs, distributes, legal representatives, successors, and assigns will hold such party or parties harmless from any loss suffered or liability incurred by such party or parties in acting in accordance with this Conditional Durable Power of Attorney prior to such party's receipt of written notice of any such termination. Any party may rely upon an affidavit executed by my Attorney-in-Fact stating that s/he does not have actual knowledge of the termination of the power by revocation or by my death. All multiple counterpart originals shall have equal force and effect, and any party may rely upon a photocopy of this power without production of the original.

6. **Exculpation.** Under no circumstances shall my Attorney-in-Fact named herein incur any liability to the principal for acting or refraining from acting hereunder, except for such Attorney-in-Fact's own willful misconduct or gross negligence.

7. **Governing Law.** This Conditional Durable Power of Attorney shall be governed by the laws of the State of Tennessee in all respects, including its validity, construction, interpretation, and termination. Should any provisions herein be held invalid, such invalidity shall not affect the other provisions which shall remain in full force and effect.

**IN WITNESS WHEREOF,** I have hereunto affixed my signature this ___ day of ________________________, 2016.

___________________________________________
Name of attorney

Witness

Witness

Witness
STATE OF TENNESSEE    
COUNTY OF KNOX    

Before me, the undersigned a Notary Public in and for said State and County, duly commissioned and qualified, personally appeared _______ and ________, ________, ________, and ________________ as witnesses, to me known (or proved to me on the basis of satisfactory evidence) to be the persons described in and who executed the foregoing instrument, and acknowledged that they executed the same as their own free act and deed.

Witness my hand and official seal at office in the aforesaid county, this day of ___________________, 2016.

_______________________________________
Notary Public

My Commission Expires: __________________________
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, ___________________, execute this Authorization for Release of Medical Information ("Authorization") for the purpose of authorizing the person designated herein to receive certain medical information about me.

1. **Release of Information.** As to the person authorized and designated in this Authorization, they shall have the same right as me to receive information regarding any proposed health care, and to receive and review my medical records, and to consent to the disclosure of my medical records to others. Specifically, I intend, by executing this Authorization, and pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320d and 45 C.F.R. §§ 160 & 164, to authorize any physician, clinic, hospital, health plan, pharmacy, health care clearinghouse, laboratory, or other health care provider or covered entity (as those terms are defined in 45 C.F.R. § 160.103) to give, disclose, and release any and all individually identifiable health information of mine, regardless of whether it is protected health information, including psychotherapy notes, to the designated person identified herein. Such information may be disclosed to such person verbally, as well as by electronic transmission, mail, or facsimile transmission. Additionally, the person designated in this Authorization shall be entitled to inspect and copy the specific information disclosed to them pursuant to this Authorization. I fully understand that information disclosed under this Authorization may be subject to redisclosure by the person designated herein and no longer protected by HIPAA or specifically the privacy rules of 45 C.F.R. §164.

2. **Use of Information.** Any information disclosed to the person designated herein may be used for any purpose, including but not limited to determining whether or not I am so disabled or incapacitated so as to be unable to continue to practice law and for obtaining a certification from a physician to that effect.

3. **Designation.** The following person is authorized to receive the information described in the Authorization: _____________________.

4. **Revocation.** This Authorization shall be valid until revoked by me in a writing that makes specific reference to this Authorization. Any such written revocation shall qualify as an "expiration event" for the purposes of HIPAA. No revocation of this Authorization shall be effective to prevent disclosure of records or communication until it is received by the person, persons, or entity otherwise authorized to disclose such records or communications.

5. **Reliance.** Any party may rely on a copy of this Authorization.

6. **Expiration.** This Authorization shall expire thirty (30) days after my death unless validly revoked prior to that date.

[signatures on following page]
IN WITNESS WHEREOF, I have duly executed this Authorization for Release of Medical Information on this _______ day of September, 2016.

________________________________________

________________________________________

SSN: __________

We, the undersigned, attest that we witnessed the signing of this document by __________ ______ on the date stated above.

Witness:

________________________________________

Signature

________________________________________

Print Name

Witness:

________________________________________

Signature

________________________________________

Print Name

STATE OF TENNESSEE  )
COUNTY OF KNOX     )

Before me, the undersigned a Notary Public in and for said State and County, duly commissioned and qualified, personally appeared ________________, the within named bargainor, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), who acknowledged that s/he executed the written instrument for the purposes set forth therein.

Witness my hand and official seal at office in the aforesaid county, this __ day of _____________, 2016.

________________________________________

Notary Public

My Commission Expires: ___________________