MEDICAL POWER OF ATTORNEY
MARY CATHERINE RUNDBLAD

DESIGNATION OF HEALTH CARE AGENT.

I, MARY CATHERINE RUNDBLAD, appoint:

Name:	GORDON ROBERT RUNDBLAD
Address:	7106 Shumard Circle
	Austin, Texas 78759
Phone:	512-335-7052

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS: NONE

DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved, annulled, or declared void unless this document provides otherwise.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. <u>First Alternate Agent</u>

Name:	KAREN SUZANNE WALKER
Address:	408 Point Venture Blvd. South
	Lago Vista, Texas 78645
Phone:	512-426-5358

B. <u>Second Alternate Agent</u>

Name:	RAYMOND P. VOITH
Address:	7105 Shumard Circle
	Austin, Texas 78759
Phone:	(Home) 512-258-3230; (Cell) 512-426-5358

The original of this document is kept at 7106 Shumard Circle, Austin, Texas 78759.

The following individuals or institutions have signed copies:

Name: _____
Address: _____
_____

Name: _____
Address: _____
_____

DURATION.

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

(IF APPLICABLE) This power of attorney ends on the following date: _____

PRIOR DESIGNATIONS REVOKED.

I revoke any prior medical power of attorney.

DISCLOSURE STATEMENT

THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are unable to make the decisions for yourself. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician. Your agent's authority is effective when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about

your health care as you would have if you were able to make health care decisions for yourself.

It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing facility, or residential care facility, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not allow a person to serve as both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions that you intend to have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to make those decisions, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void.

This document may not be changed or modified. If you want to make changes in this document, you must execute a new medical power of attorney.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. If you designate an alternate agent, the alternate agent has the same authority as the agent to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

(1) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR

(2) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

(1) the person you have designated as your agent;
(2) a person related to you by blood or marriage;
(3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
(4) your attending physician;
(5) an employee of your attending physician;
(6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
(7) a person who, at the time this medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that I have read and understand the information contained in the above disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)

SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this medical power of attorney on 16 day of July, 2019, at Austin, Texas.

Mary Rundblad
MARY CATHERINE RUNDBLAD

STATE OF TEXAS §
§
COUNTY OF TRAVIS §

This instrument was acknowledged before me on the 16th day of July, 2019, by MARY CATHERINE RUNDBLAD.

A. Lynn Tiemann
Notary Public, State of Texas

SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

STATEMENT OF FIRST WITNESS.

NOTARY PUBLIC STATE OF TEXAS
A LYNN TIEMANN
Notary ID # 4645101
My Commission Expires
April 9, 2020

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Witness signature: Brenda Jo Steele

Print name: Brenda Jo Steele Date: 7-16-19

Address: 14309 Richard Walker Blvd., Austin, Texas 78728

SIGNATURE OF SECOND WITNESS.

Witness signature: G Gaye Thompson

Print name: G. Gaye Thompson Date: 7-16-19

Address: 5203 Pony Chase, Austin, Texas 78727

HIPAA Authorization

My name is MARY CATHERINE RUNDBLAD. I currently reside at 7106 Sumard Circle, Austin, Travis County, Texas 78759. Despite the provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), I want my health care providers to provide any and all of my protected medical information which any of the following named designated representatives may request to the designated representative making the request. Therefore, I am making this authorization pursuant to HIPAA and the regulations promulgated under HIPAA, including 45 CFR 164.501 and 45 CFR Sec. 164.508.

1. In this authorization:

1.1. A "covered entity" shall mean any health care provider as defined by HIPAA, including but not limited to a doctor (including but not limited to a physician, podiatrist, chiropractor, or osteopath), psychiatrist, psychologist, dentist, therapist, nurse, hospital, clinic, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate.

1.2. "Health information" means any and all information described in or protected by HIPAA, including but not limited to any and all health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my health care.

1.3. A "designated representative" shall mean a person named in Paragraph 4 below.

2. I authorize and direct each covered entity to disclose to any one or more of the designated representatives any and all health information he or she may request.

3. I also authorize and direct each covered entity, together with its employees and other agents, to discuss my health information with one or more of the designated representatives and to answer questions about my health information which any of the designated representatives may ask, whether or not I am incapacitated at the time.

4. My designated representatives are:

Name: GORDON R. RUNDBLAD
Address: 7106 Shumard Circle
Austin, Texas 78759
Phone: 512-335-7052

Name: KAREN SUZANNE WALKER
Address: 408 Point Venture Blvd. South
Lago Vista, Texas 78645
Phone: 512-426-5358

Name: RAYMOND P. VOITH
Address: 7105 Shumard Circle
Austin, Texas 78759
Phone: (Home) 512-258-3230
(Cell) 512-426-5358

5. Each designated representative shall have co-equal authority to request and receive health information and is not required to act jointly with the other designated representatives, if any.

6. By signing this authorization, I acknowledge that the health information used or disclosed pursuant to this authorization may be subject to re-disclosure by one or more of the designated representatives, and the health information once disclosed will no longer be protected by HIPAA or the rules promulgated under HIPAA. No covered entity shall require any designated representative to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this authorization.

7. I release any covered entity that acts in reliance on this authorization from any liability that may accrue from releasing any of my health information and for any actions taken by one or more of the designated representatives.

8. Each designated representative is authorized to bring a legal action in any appropriate forum against any covered entity that refuses to recognize and accept this authorization. Additionally, each designated representative is authorized to sign any documents that he or she deems appropriate to obtain the health information.

9. This authorization shall terminate on the first to occur of: (1) two years following my death or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it. This authorization is not affected by my subsequent disability or incapacity.

10. A copy or facsimile of this original authorization shall be accepted as though it were an original document.

Signed the 16th day of July, 2019.

Mary Rundblad
MARY CATHERINE RUNDBLAD

THE STATE OF TEXAS §
§
COUNTY OF TRAVIS §

This instrument was acknowledged before me on the 16th day of July, 2019, by MARY CATHERINE RUNDBLAD.

A. Lynn Tiemann
Notary Public, State of Texas

NOTARY PUBLIC
STATE OF TEXAS
A LYNN TIEMANN
Notary ID # 4645101
My Commission Expires
April 9, 2020