MTC13916-10159

2010-009913
Klamath County, Oregon

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RECORDING COVER SHEET

THIS COVER SHEET HAS BEEN PREPARED BY THE PERSON REPRESENTING THE ATTACHED INSTRUMENT FOR RECORDING. ANY ERRORS IN THIS COVER SHEET DO NOT AFFECT THE TRANSACTION(S) CONTAINED IN THE INSTRUMENT ITSELF.

After Recording, Return To:
Justin Robert Azevedo
3015 Paramont Street
Klamath Falls, OR 97603

1. Name(s) of the Transaction(s):
Power of Attorney

2. Direct Party (Grantor):

Justin Robert Azevedo

3. Indirect Party (Grantee):

Bridgitte Michelle Griffin

4. True and Actual Consideration Paid:

n/a

5. Legal Description:
n/a

AMERITITLE ,has recorded this instrument by request as an accomodation only, and has not examined it for regularity and sufficiency or as to its effect upon the title to any real property that may be described therein.

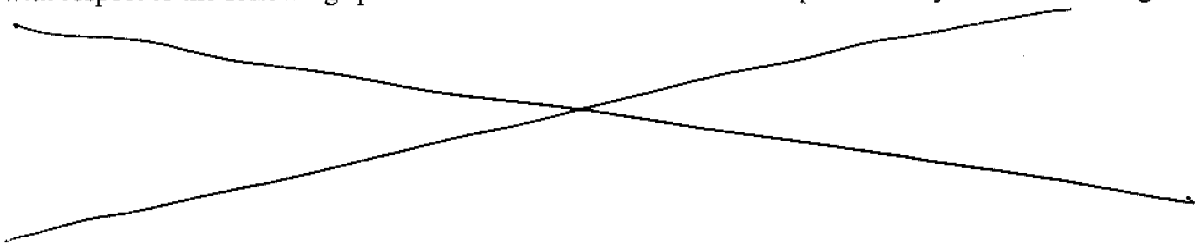
52Amt

Durable Unlimited Power of Attorney

Effective Only Upon Disability

Notice to Adult Signing this Document: This is an important document. Before signing this document, you should know these important facts. By signing this document, you are not giving up any powers or rights to control your finances and property yourself. In addition to your own powers and rights, you are giving another person, your attorney-in-fact, broad powers to handle your finances and property, which may include powers to encumber, sell or otherwise dispose of any real or personal property without advance notice to you or approval by you. THE POWERS GRANTED UNDER THIS DOCUMENT WILL ONLY GO INTO EFFECT IF YOU BECOME DISABLED OR INCAPACITATED, AS CERTIFIED BY YOUR PRIMARY PHYSICIAN, OR BY ANOTHER ATTENDING PHYSICIAN, IF YOUR PRIMARY PHYSICIAN IS NOT AVAILABLE. This document does not authorize anyone to make medical or other health care decisions for you. If you own complex or special assets such as a business, or if there is anything about this form that you do not understand, you should ask a lawyer to explain this form to you before you sign it. If you wish to change your durable unlimited power of attorney, you must complete a new document and revoke this one. You have the right to revoke the designation of the attorney-in-fact and the right to revoke this entire document at any time and in any manner. You may revoke this document at any time by destroying it, by directing another person to destroy it in your presence or by signing a written and dated statement expressing your intent to revoke this document. If you revoke this document, you should notify your attorney-in-fact and any other person to whom you have given a copy of the form. You also should notify all parties having custody of your assets. These parties have no responsibility to you unless you actually notify them of the revocation. If your attorney-in-fact is your spouse and your marriage is annulled, or you are divorced after signing this document, this document may become invalid. Since some third parties or some transactions may not permit use of this document, it is advisable to check in advance, if possible, for any special requirements that may be imposed. You should sign this form only if the attorney-in-fact you name is reliable, trustworthy and competent to manage your affairs. Generally, you may designate any competent adult as the attorney-in-fact under this document.

I, JUSTIN ROBERT AZEVEDO, of 3015 PARAMONT STREET, City of KLAMATH FALLS, State of OREGON, as Principal, do appoint BRIDGITTE MICHELLE GRIFFIN, of 3015 PARAMONT STREET, City of KLAMATH FALLS, State of OREGON, as my attorney-in-fact to act in my name, place and stead in any way which I myself could do, if I were personally present, with respect to the following specific matters to the extent that I am permitted by law to act through an agent:



I grant my attorney-in-fact the maximum power under law to perform any act on my behalf that I could do personally, including but not limited to, all acts relating to any and all of my financial transactions and/or business affairs including all banking and financial institution transactions, all real estate or personal property transactions, all insurance or annuity transactions, all claims and litigation, and any and all business transactions.

This power of attorney shall only become effective upon my disability or incapacitation, as certified by my primary physician, or if my primary physician is not available, by any other attending physician. This power of attorney grants no power or authority regarding healthcare decisions to my designated attorney-in-fact.

If the attorney-in-fact named above is unable or unwilling to serve, then I appoint ROBERT LEROY AZEVEDO, of ~~LA~~ _____, City of LAKEVIEW, State of OREGON, to be my successor attorney-in-fact for all purposes hereunder.

My attorney-in-fact is granted full and unlimited power to act on my behalf in the same manner as if I were personally present. My attorney-in-fact accepts this appointment and agrees to act in my best interest as he or she considers advisable. To induce any third party to rely upon this power of attorney, I agree that any third party receiving a signed copy or facsimile of this power of attorney may rely upon such copy, and that revocation or termination of this power of attorney shall be ineffective as to such third party until actual notice or knowledge of such revocation or termination shall have been received by such third party. I, for myself and for my heirs, executors, legal representatives and assigns, agree to indemnify and hold harmless any such third party from any and all claims that may arise against such third party by reason of such third party having relied on the provisions of this power of attorney. This power of attorney may be revoked by me at any time and is automatically revoked upon my death. My attorney-in-fact shall not be compensated for his or her services nor shall my attorney-in-fact be liable to me, my estate, heirs, successors, or assigns for acting or refraining from acting under this document, except for willful misconduct or gross negligence. Revocation of this document is not effective unless a third party has actual knowledge of such revocation.

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

Signature and Declaration of Principal

I, JUSTIN ROBERT AZEVEDO, the principal, sign my name to this power of attorney this 8 day of APRIL, 2010 and, being first duly sworn, do declare to the undersigned authority that I sign and execute this instrument as my power of attorney and that I sign it willingly, or willingly direct another to sign for me, that I execute it as my free and voluntary act for the purposes expressed in the power of attorney and that I am eighteen years of age or older, of sound mind and under no constraint or undue influence, and that I have read and understand the contents of the notice at the beginning of this document.

Justin R Azevedo
Signature of Principal

Witness Attestation

I, LORI THORNTON, the first witness, and I, NICOLE CLAYBAUGH, the second witness, sign my name to the foregoing power of attorney being first duly sworn and do declare to the undersigned authority that the principal signs and executes this instrument as his/her power of attorney and that he/she signs it willingly, or willingly directs another to sign for him/her, and that I, in the presence and hearing of the principal, sign this power of attorney as witness to the principal's signing and that to the best of my knowledge the principal is eighteen years of age or older, of sound mind and under no constraint or undue influence.

Lori Thornton
Signature of First Witness

Nicole Claybaugh
Signature of Second Witness

Notary Acknowledgment

State of Oregon County of Klamath

Subcribed, sworn to and acknowledged before me by Justine Azevedo, the Principal, and subscribed and sworn to before me by April 8, 2010, witness, this ______ day of (see attached) ______.

K. Linville
Notary Signature

OFFICIAL SEAL
K. LINVILLE
NOTARY PUBLIC-OREGON
COMMISSION NO. 413953
MY COMMISSION EXPIRES FEB. 9, 2011

Notary Public,

In and for the County of Klamath State of Oregon

My commission expires: 2-9-11

Seal

Acknowledgment and Acceptance of Appointment as Attorney-in-Fact

I, BRIDGITTE MICHELLE GRIFFIN have read the attached power of attorney and am the person identified as the attorney-in-fact for the principal. I hereby acknowledge that I accept my appointment as Attorney-in-Fact and that when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate record of all actions, receipts and disbursements on behalf of the principal.

[signature]
Signature of Attorney-in-Fact

4-8-10
Date

Acknowledgment and Acceptance of Appointment as Successor Attorney-in-Fact

I, ROBERT LEROY AZEVEDO have read the attached power of attorney and am the person identified as the successor attorney-in-fact for the principal. I hereby acknowledge that I accept my appointment as Successor Attorney-in-Fact and that, in the absence of a specific provision to the contrary in the power of attorney, when I act as agent I shall exercise the powers for the benefit of the principal; I shall keep the assets of the principal separate from my assets; I shall exercise reasonable caution and prudence; and I shall keep a full and accurate record of all actions, receipts and disbursements on behalf of the principal.

Robert Leroy Azevedo
Signature of Successor Attorney-in-Fact

7-10-2010
Date

STATE OF OREGON,
County of KLAMATH } ss.

On APRIL 8, 2010 (DATE), before me personally appeared * * *LORI THORNTON AND NICOLE CLAYBAUGH* *, whose identity was established to my satisfaction, and who executed the foregoing instrument, acknowledging to me that the same was executed freely and voluntarily.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal on the date first written above.

K. Linville
Notary Public for Oregon
My commission expires 2-9-11

OFFICIAL SEAL
K. LINVILLE
NOTARY PUBLIC-OREGON
COMMISSION NO. 413953
MY COMMISSION EXPIRES FEB. 9, 2011

Health Care Power of Attorney
Appointment of Health Care Agent and Proxy

Notice to Adult Signing this Document: This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney-in-fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney-in-fact to make health care decisions for you. Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney-in-fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so.

The authority of the attorney-in-fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

Additionally, when exercising authority to make health care decisions for you, the attorney-in-fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney-in-fact by including them in this document or by making them known to the attorney-in-fact in another manner.

When acting pursuant to this document, the attorney-in-fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

GENERALLY, you may designate any competent adult as the attorney-in-fact under this document. You have the right to revoke the designation of the attorney-in-fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician. If you execute this document and create a valid Health Care Power of Attorney with it, it will revoke any prior, valid power of attorney for health care that you created, unless you indicate otherwise in this document. This document is not valid as a Health Care Power of Attorney unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney-in-fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

I, JUSTIN ROBERT AZEVEDO, residing at 3015 PARAMONT STREET,
City of KLAMATH FALLS, State of OREGON, appoint the following person as my attorney-in-fact for health care decisions, my health care agent, and confer upon this person my health care proxy. This person shall hereafter be referred to as my "health care representative":

BRIDGITTE MICHELLE GRIFFIN, residing at 3015 PARAMONT ST,

City of KLAMATH FALLS, State of OREGON.

I grant my health care representative the maximum power under law to perform any acts on my behalf regarding health care matters that I could do personally under the laws of the State of OREGON, including specifically the power to make any health decisions on my behalf, upon the terms and conditions set forth below. My health care representative accepts this appointment and agrees to act in my best interest as he or she considers advisable. This health care power of attorney and appointment of health care agent and proxy may be revoked by me at any time and is automatically revoked on my death. However, this power of attorney shall not be affected by my present or future disability or incapacity.

This health care power of attorney and appointment of health care agent and proxy has the following terms and conditions:

1. If I have signed a Living Will or Directive to Physicians, and it is still in effect, I direct that my health care representative abide by the directions that I have set out in that document.

2. If at any time I should have an incurable injury, disease, or illness which has been certified as a terminal condition by my attending physician and one additional physician, both of whom have personally examined me, and such physicians have determined that there can be no recovery from such condition and my death is imminent, and where the application of life prolonging procedures would serve only to artificially prolong the dying process, then:

I direct my health care representative to assure that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the administration of nutrition and/or hydration, or the performance of any medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain.

3. If at any time I should have been diagnosed as being in a persistent vegetative state which has been certified as incurable by my attending physician and one additional physician, both of whom have personally examined me, and such physicians have determined that there can be no recovery from such condition, and where the application of life prolonging procedures would serve only to artificially prolong the dying process, then:

I direct that my health care representative assure that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the administration of nutrition and/or hydration, or the performance of any medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain.

THE FOLLOWING INSTRUCTIONS (IN BOLDFACE TYPE) ONLY APPLY IF I HAVE SIGNED MY NAME IN THIS SPACE: Bridgitte Griffin

However, if at any time I should have been diagnosed as being in a persistent vegetative state which has been certified as incurable by my attending physician and one additional physician, both of whom have personally examined me, and such physicians have determined that there can be no recovery from such condition, I also direct that my health care representative have sole authority to order the withholding of any aid, including the administration of nutrition, hydration, and any other medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain.

4. If I am able to communicate in any manner, including even blinking my eyes, I direct that my health care representative try and discuss with me the specifics of any proposed health care decision.

5. If I have any further terms or conditions, I state them here:

I have discussed my health care wishes with the person whom I have herein appointed as my health care representative, I am fully satisfied that the person who I have herein appointed as my health care representative will know my wishes with respect to my health care and I have full faith and confidence in their good judgement.

I further direct that my health care representative shall have full authority to do the following, should I lack the capacity to make such a decision myself, provided however, that this listing shall in no way limit the full authority that I give my health care representative to make health care decisions on my behalf:

a. to give informed consent to any health care procedure;

b. to sign any documents necessary to carry out or withhold any health care procedures on my behalf, including any waivers or releases of liabilities required by any health care provider;

c. to give or withhold consent for any health care or treatment;

d. to revoke or change any consent previously given or implied by law for any health care treatment;

e. to arrange for or authorize my placement or removal from any health care facility or institution;

f. to require that any procedures be discontinued, including the withholding of any medical treatment and/or aid, including the administration of nutrition, hydration, and any other medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain, subject to the conditions earlier provided in this document.

g. to authorize the administration of pain-relieving drugs, even if they may shorten my life.

I desire that my wishes with respect to all health care matters be carried out through the authority that I have herein provided to my health care representative, despite any contrary wishes, beliefs, or opinions of any members of my family, relatives, or friends.

I have read the Notice that precedes this document. I understand the full importance of this appointment, and I am emotionally and mentally competent to make this appointment of health care representative.

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

I have read the Notice that precedes this document. I understand the full importance of this appointment. I am over 18 years of age and I am emotionally and mentally competent to make this appointment of health care representative.

Date 4-8-10

Signature of person granting health care power of attorney and appointing health care representative

Witness Attestation

I, LORI THORNTON, the first witness, and I, NICOLE CLAYBAUGH, the second witness, sign my name to the foregoing power of attorney being first duly sworn and do declare to the undersigned authority that the principal signs and executes this instrument as his/her power of attorney and that he/she signs it willingly, or willingly directs another to sign for him/her, and that I, in the presence and hearing of the principal, sign this power of attorney as witness to the principal's signing and that to the best of my knowledge the principal is eigh-

teen years of age or older, of sound mind and under no constraint or undue influence. I am not related to the principal, nor am I entitled to any portion of the principal's estate. I also do not provide health care services to the principal and am not financially responsible for the principal's health care.

Signature of First Witness

Signature of Second Witness

1912 Wall St Klls OR 97603
Address of First Witness

5830 Barnett Ave, Klamath Falls OR 97603
Address of Second Witness

Notary Acknowledgment

State of Oregon County of Klamath

On April 8, 20 10, Justin Cazvedo

came before me personally and, under oath, stated that he/~~she~~ is the person described in the above document and he/~~she~~ signed the above document in my presence. The witnesses Tori Thornton and Nicole Claybaugh also came before me attested to the above statement and signed the document in my presence.

Notary Public Signature

Notary Public In and for the County of Klamath State of Oregon

My commission expires: 2-9-11 Seal

OFFICIAL SEAL
K. LINVILLE
NOTARY PUBLIC-OREGON
COMMISSION NO. 413953
MY COMMISSION EXPIRES FEB. 9, 2011

Acceptance of Appointment as Attorney-in-Fact

I accept my appointment as Attorney-in-Fact.

Signature of Attorney-in-Fact

BRIDGITTE MICHELLE GRIFFIN
Printed Name of Attorney-in-Fact