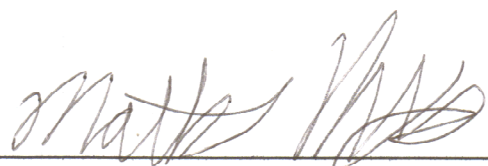


Please have both applicant and agent of patient sign their name and date under the appropriate line and return this document to the appropriate median after reading the terms of this document.

I hereby understand the duties and procedures of a Health Care Proxy Agent under the terms and conditions for one mathew Riexinger. By signing this document both Agent(s) and applicant understand the full responsibility of the duty of the Agent, and also understand that the decisions made by the Agent(s) are made in the best interest of the applicant mathew Riexinger, and cannot and will not be liable for any problems with the applicants health due to any decisions made by one Brenda walters, if any problems do occur. Signing this document agrees to the terms above.

Applicant signature  Date 11/21/05

Agent signature _____ Date _____

Agent signature (If a second Agent is named)

_____ Date _____

State of New York
George E. Pataki, Governor

Department of Health
Antonia C. Novella, M.D., M.P.H., Dr. P.H., Commissioner