DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, Alan Portman, of 11931 Ameling Rd, Maryland Heights, Missouri 63043, being of sound mind, voluntarily create this Durable Power of Attorney for Health Care.

PRIOR DESIGNATIONS

I revoke any prior Durable Power of Attorney for Health Care.

APPOINTMENT OF HEALTH CARE ATTORNEY-IN-FACT

In the event that I have been determined to be incapable of providing informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my attorney-in-fact for health care decisions:

Name: Yael Portman
Address: 11931 Ameling Rd, Maryland Heights, Missouri, 63043
Telephone: (314) 413-4833
Relationship: child

APPOINTMENT OF ALTERNATE HEALTH CARE ATTORNEY-IN-FACT

If I revoke Yael Portman's authority or if Yael Portman is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate attorney-in-fact:

Name: Merav Portman
Address: 3543 S. Scott Blvd, Columbia, Missouri, 65203
Telephone: (314) 518-7551
Relationship: child

ATTORNEY-IN-FACT'S AUTHORITY

My attorney-in-fact is authorized to act for me in all matters relating to my health care. My attorney-in-fact's powers include, but are not limited to:

- Full power to consent, refuse consent, or withdraw consent to all medical, surgical, hospital and related health care treatments and procedures on my behalf, according to my wishes as stated in this document, or as stated in a separate Living Will, Health Care Directive, or other similar type document, or as expressed to my attorney-in-fact by me;

- Full power to make decisions on whether to provide, withhold, or withdraw artificial nutrition and hydration on my behalf, according to my wishes as stated in this document, or as stated in a separate Living Will, Health Care Directive, or other similar type document, or as expressed to my attorney-in-fact by me;
- Full power to review and receive any information regarding my physical or mental health, including medical and hospital records, in accordance with the *Health Insurance Portability and Accountability Act of 1996,* 42 USC 1320d ("HIPAA"), and the *American Recovery and Reinvestment Act of 2009* ("ARRA");
- Full power to sign any releases in order to obtain this information;
- Full power to sign any documents required to request, withdraw, or refuse treatment or to be released or transferred to another medical facility.

My attorney-in-fact does not have authority to act for me for any other purpose unrelated to my health care. All of my attorney-in-fact's actions under this power during any period when I am unable to make or communicate health care decisions have the same effect on my heirs, devisees and personal representatives as if I were competent and acting for myself.

WHEN ATTORNEY-IN-FACT'S AUTHORITY BECOMES EFFECTIVE

The designation of my attorney-in-fact will become effective as soon as this document is signed and will remain in effect until my death, or until I revoke it. This designation will not be affected by my subsequent disability or incompetence.

ATTORNEY-IN-FACT'S OBLIGATIONS

My attorney-in-fact will make health care decisions for me in accordance with this document, and in accordance with any instructions I give in a Living Will, Health Care Directive or other such document (either included in this document or as a separate document), and my other wishes to the extent known to my attorney-in-fact. To the extent my wishes are unknown, my attorney-in-fact will make health care decisions for me in accordance with what my attorney-in-fact determines to be in my best interest. In determining my best interest, my attorney-in-fact will consider my personal values to the extent known to my attorney-in-fact.

EFFECT OF COPY

A copy of this Durable Power of Attorney for Health Care has the same effect as the original.

SEVERABILITY

If any part or parts of this Durable Power of Attorney for Health Care is found to be invalid or illegal under applicable law by a court of competent jurisdiction, the invalidity or illegality of such part or

parts shall not in any way affect the remaining parts, and this document shall be construed as though the invalid or illegal part or parts had never been included herein. But if the intent of this Durable Power of Attorney for Health Care would be defeated by such construction, then it shall not be so construed.

SIGNATURE

This Durable Power of Attorney for Health Care is made after careful reflection, while I am of sound mind. I am fully informed as to all contents of this document and understand the full import of this grant of powers to my attorney-in-fact. I fully understand that by signing this document, I will permit my attorney-in-fact to make health care decisions for me. I understand that my signature on this document gives my attorney-in-fact authority to provide, withhold, or withdraw consent to health care treatments or procedures on my behalf; to apply for public benefits to defray the cost of my health care; and to authorize my admission to or transfer from a health care facility. I further affirm that I am not signing this document as a condition of treatment or admission to a health care facility.

Signature: 

Name: Alan Portman

Date: 7/15/2026

Place: Fenton, Missouri

STATEMENT OF WITNESSES

(Use if document is not notarized.)

I, the undersigned witness, declare that Alan Portman, the person who signed this document, is personally known to me and appears to be of sound mind and acting of their own free will and under no duress. They signed (or asked another to sign for them) this document in my presence. I further declare that I am at least 18 years of age, I am not entitled to any portion of Alan Portman's estate, not financially responsible for Alan Portman's health care, not named as Alan Portman's health care Attorney-in-fact in this document, and that I am not married to Alan Portman and not related to Alan Portman by blood or adoption.

First witness

Ryan Accola-House
(signature of witness)

Ryan Accola-House
(print name)

1297 N. Hwy Dr.
(address)

Fenton, MO
(city) (state)

July 14, 2026
(date)

Second witness

(signature of witness)

David Blanc
(print name)

1297 N. Highway Dr
(address)

Fenton MO 63026
(city) (state)

7/14/26
(date)

NOTARIZATION

STATE OF MISSOURI

COUNTY (OR CITY) OF St. Louis

On this 14 day of July, 2026 before me, Rebecca Nicole Moreland a Notary Public in and for said state, personally appeared Alan Portman, known to me (or satisfactorily proven) to be the person who executed the within Durable Power of Attorney for Health Care, and acknowledged to me that he/she executed the same for the purposes therein stated.

Rebeccanicolemoreland
Notary Public

REBECCA NICOLE MORELAND
NOTARY PUBLIC, NOTARY SEAL
STATE OF MISSOURI
ST. LOUIS COUNTY
COMMISSION # 23735829
MY COMMISSION EXPIRES: 10/1/2027

My commission expires: 10/1/2027

RECORD OF COPIES

Record of people and institutions to whom I have given a signed copy of this document:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

DECLARATION

If I, Alan Portman, become incapacitated and am unable to direct my health care providers as to my own health care, I direct that this statement be read as a true reflection of my health care wishes.

I understand that Missouri law does not allow me to direct that comfort care be withheld or to direct the treatment that I will receive if I am diagnosed to be in a permanent coma or a persistent vegetative state. However, I ask that my wishes regarding the giving of comfort and care and the treatment I will receive if I am in a permanent coma or a persistent vegetative state, as detailed in this document, be followed regardless of whether it may go beyond what state law allows. I ask that my right to direct my own health care as guaranteed by the U.S. Constitution be followed and given precedence in this matter.

DEFINITIONS

For the purposes of this document, the following definitions apply:

1. **"Artificially administered food and water"** (or artificial nutrition and hydration) means the provision of nutrients or fluids by a tube inserted in vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).
2. **"Attending physician"** means the physician licensed by the state board of medicine, selected by or assigned to the patient, and who has primary responsibility for the treatment and care of the patient.
3. **"Comfort care"** means treatment, including prescription medication, provided to the patient for the sole purpose of alleviating pain. Artificially administered food and water is not included.
4. **"Health care provider"** or "provider" means any person licensed, certified, or otherwise authorized by law to administer health care in the ordinary course of business or practice of a profession.
5. **"Irreversible (Permanent) Coma"** means a profound state of unconsciousness caused by disease, injury, poison, or other means and for which it has been determined that there exists no reasonable expectation of regaining consciousness.
6. **"Life-prolonging procedure"** (or **"life-sustaining procedure"**) means any medical procedure, treatment, or intervention which sustains, restores, or supplants a spontaneous vital function. In this document the term does not include sustenance and hydration administration, or the provision of medication or the performance of medical procedure, when such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.

7. **"Persistent vegetative state"** means a permanent and irreversible condition in which there is:
   a. The absence of voluntary action or cognitive behavior of any kind.
   b. An inability to communicate or interact purposefully with the environment.
8. **"Terminal condition"** means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

MEDICAL DIRECTIONS AND END-OF-LIFE DECISIONS

I direct that my health care providers and others involved in my care, provide, withhold, or withdraw treatment in accordance with my directions below: (Review and initial where indicated)

1. If I have an incurable and irreversible (terminal) condition that will result in my death within a relatively short time, I direct that:

   - I be removed from any artificial life support or any additional life-prolonging treatment. ____ (my initials)
   - I not be artificially administered food and water, realizing this may hasten my death. ____ (my initials)
   - I be provided comfort care, and relief from pain, including any pain reduction medication, even if doing so would prolong my life.

2. If I am diagnosed as being in an irreversible coma and, to a reasonable degree of medical certainty, I will not regain consciousness, I direct that

   - I be removed from any artificial life support or any additional life-prolonging treatment. ____ (my initials)
   - I not be artificially administered food and water, realizing this may hasten my death. ____ (my initials)
   - I be provided comfort care, and relief from pain, including any pain reduction medication, even if doing so would prolong my life.

3. If I am diagnosed as being in a persistent vegetative state and, to a reasonable degree of medical certainty, I will not regain consciousness, I direct that:

   - I be removed from any artificial life support or any additional life-prolonging treatment. ____ (my initials)

- I not be artificially administered food and water, realizing this may hasten my death. ____ (my initials)
- I be provided comfort care, and relief from pain, including any pain reduction medication, even if doing so would prolong my life.

ADDITIONAL INSTRUCTIONS

- I direct that I do not wish CPR or other similar life saving care.

I understand that I may change the above-listed directives at any time by revoking this declaration and writing a new one.

EFFECT OF COPY

A copy of this Declaration has the same effect as the original.

SEVERABILITY

If any part or parts of this Declaration is found to be invalid or illegal under applicable law by a court of competent jurisdiction, the invalidity or illegality of such part or parts shall not in any way affect the remaining parts, and this document shall be construed as though the invalid or illegal part or parts had never been included herein. But if the intent of this Declaration would be defeated by such construction, then it shall not be so construed.

SIGNATURE

This document is made upon careful reflection. Options that I have considered and rejected are not printed above. I confirm that the health care directions contained herein were made after careful consideration and in full awareness of other options that may have been available to me. I declare that I am an adult in the State of Missouri, that I understand the full import of this declaration, and that I am emotionally and mentally competent to give these directions.

Signed at Fenton, in the State of Missouri, this 14th day of July, 2026.

Signature: _____

Name: Alan Portman

Address: 11931 Ameling Rd

Maryland Heights, Missouri 63043

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of the State of Missouri that:

1. The individual who signed or acknowledged this Declaration, Alan Portman, is personally known to me, or their identity was proven to me by convincing evidence;
2. Alan Portman appeared to be eighteen (18) years of age or older, or of the legal age in this state to create this type of document;
3. I am of at least eighteen (18) years of age and Alan Portman signed or acknowledged this Declaration in my presence;
4. Alan Portman appears to be of sound mind and under no duress, fraud, or undue influence;
5. I am not a person appointed as Alan Portman's health care attorney-in-fact;
6. I am not Alan Portman's health care provider, an employee of Alan Portman's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly; and
7. I am not related to Alan Portman by blood or marriage and I would not be entitled to any portion of Alan Portman's estate on their death.

First witness

Ryan Accola-House
(signature of witness)

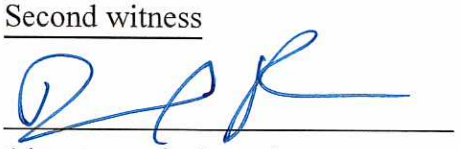
RYAN Accola-HOUSE
(print name)

1297 N. Hwy Dr
(address)

Fenton, MO
(city) (state)

July 14, 2024
(date)

Second witness


(signature of witness)

Daniel Ruiz
(print name)

8912 Powell ave
(address)

St. Louis
(city) (state)

07/14/2026
(date)

RECORD OF COPIES

Record of people and institutions to whom I have given a signed copy of this document:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____