Date: _____

Client Information
Power of Attorney (POA)

Name (First, Middle, Last):	Social Security Number:	Date of Birth:	
Name (Other names known by):	Email:		US Citizen: ☐Yes ☐ No
Spouse Name:	Home Phone:	Cell Phone:	
Street Address:	City:	State:	Zip:

Power of Attorney (POA) Questions:

	Please select the documents you want prepared: ☐ Durable POA ☐ Medical POA ☐ HIPAA ☐ Physicians Directive	**Yes √**	**No √**
1.	Do you want your agent to be able to transfer real property?		
2.	Do you want your agent to be able to change your beneficiaries on life insurance policies and retirement accounts?		
3.	Do you want to record your Power of Attorney? (must record for real property transactions-leases, mortgages, sales, etc.)?		
4.	Do you want your agent to be able to make gifts? If yes: ☐ To Anyone ☐ To Descendants Only ☐ Unlimited Amount ☐ Limited Amount $ _____ ☐ Annual Exclusion Only ☐ Medicaid Purposes		
5.	When do you want your power of attorney to become effective? ☐ Immediately ☐ Only upon subsequent disability or incapacity		

If you will be providing a signed copy to someone who is not your agent, please name the individuals & institutions below. Check each box that applies:

Name: _____ ☐ POA

Address: _____ ☐ Med POA

_____ ☐ HIPAA

Name: _____ ☐ POA

Address: _____ ☐ Med POA

_____ ☐ HIPAA

Name: _____ ☐ POA

Address: _____ ☐ Med POA

_____ ☐ HIPAA

For identification purposes, please select the one you will be providing: ☐ Driver's License ☐ State Identification Card

PATSY R. GLENN, CPA
ATTORNEY AT LAW
5048 Trail Lake Dr., Ft. Worth, TX 76133
(817) 346-3312; (817) 386-5888

POWER OF ATTORNEY AGENTS

List the name and address of each person who you want to serve as agent under your Durable or Medical Power of Attorney. For each Power of Attorney, indicate if that person will act as the primary agent, a co-agent, or only as an alternate agent.

Name (First, Middle, Last): _____ Relationship: _____

Address: _____ Phone Number: _____

_____

☐ This person will serve as agent as indicated below:

DURABLE POWER OF ATTORNEY:
☐ Primary Agent
☐ Co-Agent
☐ Alternate Agent #____ (if Primary or Alternate #___ cannot serve)

MEDICAL POWER OF ATTORNEY:
☐ Primary Agent
☐ Alternate Agent #____ (if Primary or Alternate #___ cannot serve)

HIPAA--Include this person to receive my medical information: ☐ Yes ☐ No This person will serve as:
☐ Primary
☐ Alternate # ___ or
☐ as one of a group of persons entitled to receive my information

☐ This person will have a signed copy of the following documents: ☐ Durable POA ☐ Medical POA ☐ HIPAA

Name (First, Middle, Last): _____ Relationship: _____

Address: _____ Phone Number: _____

_____

☐ This person will serve as agent as indicated below:

DURABLE POWER OF ATTORNEY:
☐ Primary Agent
☐ Co-Agent
☐ Alternate Agent #____ (if Primary or Alternate #___ cannot serve)

MEDICAL POWER OF ATTORNEY
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