Information Concerning the Medical Power of Attorney

This 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 no longer capable of making them 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 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.

You agent's authority begins when your doctor certifies that you lack the capacity 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 had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure 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 home, or residential care home, 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 permit a person to do 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 have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so 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 durable power of attorney for health care. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

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

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULTS. THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

(1) the person you have designated as your agent;
(2) a persona 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 power of attorney is executed, has a claim against any part of your estate after your death.

Medical Power of Attorney

I, _____, appoint:
(insert your name)

Name: _____

Address: _____

Phone: _____

as my agent to make healthcare 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:

_____

_____

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 willing to act as your agent. If the agent designated is your spouse, the designation automatically is revoked by law if your marriage is dissolved.)

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

A. First Alternate Agent

Name: _____

Address: _____

Phone: _____

B. Second Alternate Agent

Name: _____

Address: _____

Phone: _____

The original of this document is kept at:

_____

The following individuals or institutions have signed copies:

Name: _____ Address: _____

Name: _____ Address: _____

Medical Power of Attorney

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 decisions for myself.

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

PRIOR DESIGNATION REVOKED:

I revoke any prior Medical Power of Attorney.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT:

I have been provided with a disclosure statement explaining the effects of this document. I have read and understand that information contained in the disclosure statement.

YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.

I sign my name to this medical power of attorney on: _____ day of _____ (month, year) at:

City and State: _____

Signature: _____

Print Name: _____

STATEMENT OF FIRST WITNESS

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

Signature: _____

Printed Name: _____ Date: _____

Address: _____

SIGNATURE OF SECOND WITNESS

Signature: _____

Printed Name: _____ Date: _____

Address: _____

Medical Power of Attorney

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be provided for me following standards specified in the laws of Texas. If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standards of care, I acknowledge that all treatment may be withheld or removed except those to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed: _____ Date: _____

City, County, State of Residence: _____

Two competent adult witnesses must sign below, acknowledging the signature of the declaring. The witness designated as Witness I may not be a person designated to make treatment decisions for the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If the witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of the health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness I: _____ Witness II: _____

DEFINITIONS:

"Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

"Irreversible condition" means a condition, injury, or illness:

(1) that may be treated, but never cured or eliminated;
(2) that leaves a person unable to care for or make decisions for him/herself; and
(3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (i.e. kidneys, heart, liver, or lung) and serious brain disease, such as Alzheimer's dementia, may be considered irreversible early on. There is no cure, but the patient may be kept alive for a prolonged period of time if the patient receives life-sustaining treatment. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important people in your life.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney disease, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain

management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

"Explanation" Many serious illnesses may be considered irreversible early on in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family or other important people in your life.