TEXAS MEDICAL POWER OF ATTORNEY

DISCLAIMER STATEMENT

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 consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment.

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.

Your agent's authority begins when your doctor certifies that you lack the competence 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 who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once 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 medical power of attorney. 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 ADULT WITNESSES.
THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:
(1) the person you have designated as your agent;
(2) a person 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.

1. DESIGNATION OF AGENT

I, _____, hereby appoint _____ of _____ as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document or as prohibited by law. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. I hereby appoint _____ of _____ as an alternate agent.

Authority of Agent.

My agent has full and complete authority to make all health care decisions for me whenever I cannot make such decisions, unless I have otherwise indicated below. This authority includes, but is not limited to, the following:

1. To consent to the administration of pain-relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death. My comfort and freedom from pain are important to me and should be protected by my agent and physician.

2. If I am in a terminal condition, to give, to withdraw or to refuse to give informed consent to life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.

3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, intervention or other measure.

4. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all my medical and health care records.

5. To consent to further disclosure of information, and to disclose medical and related information concerning my condition and treatment to other persons.

6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.

7. To execute consents, waivers, and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any third party who acts under this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.

8. To select, employ, and discharge health care personnel and services providing home health care and the like.

9. To select, contract for my admission to, transfer me to, or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.

10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, should I become unable to make health care decisions for myself in a place where this document is not enforced.

11. To complete and sign for me the following:

(a) Consents to health care treatment, or the issuance of Do Not Resuscitate (DNR) Orders or other similar orders; and

(b) Requests for my transfer to another facility, to be discharged against health care advice, or other similar requests; and

(c) Any other document desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

2. DURATION

I understand that this power of attorney exists indefinitely from the date I execute this document or until the established end date is reached. However, I may revoke the power of attorney at any moment by notifying my agent orally or in writing. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted to my agent continues to exist until I become able to make healthcare decisions for myself.

[This power of attorney ends on the following date: [MONTH] [DAY], [YEAR]].

3. EXECUTION

YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES NOT RELATED BY BLOOD OR MARRIAGE.

4. VALIDITY.

THIS MEDICAL POWER OF ATTORNEY IS NOT VALID UNLESS:

1. YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR

2. YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

5. ORIGINAL AND COPIES OF THIS MEDICAL POWER OF ATTORNEY.

The original of this document will be kept at _____ and the following persons and institutions will have signed copies:

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

In witness whereof, I have hereunto signed my name this _____ day of ___, 20 ___

_____
Signature

WITNESSES OR NOTARY ACKNOWLEDGMENT

I attest that the Principal signed or acknowledged this Health Care Power of Attorney in my presence, that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence. I further attest that I am not an agent designated in this document, I am not the attending physician of the Principal, I am not the administrator of a nursing home in which the Principal is receiving care, and I am an adult not related to the Principal by blood, marriage or adoption.

Witness: _____ Address: _____
Witness: _____ Address: _____

NOTARY ACKNOWLEDGMENT

STATE OF TEXAS
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20 ___, by _____

_____

Notary Public/Justice of the Peace

My Commission Expires: