Advance Directive/Medical Power of Attorney – TEXAS

Name: _____Date of Birth: ____/____/____

Telephone numbers: (home) _____; (cell) _____

Address: _____

Email: _____

Complete at least **ONE** option from **Step 1** and **Step 2** and complete **Step 3**

Step 1: Choose a health care agent.

CHOOSE **ONE** OR **TWO** BOXES

☐ I choose _____; Relationship _____;
(phone number - -) and/or (email_____) as my primary health care agent to speak for me in making health care decisions if I become unable to speak for myself.

☐ I choose _____; Relationship _____;
(phone number - -) and/or (email_____) as my secondary health care agent who can speak for me in making health care decisions if I become unable to speak for myself and my primary health care agent is unable to serve.

Step 2: Provide guidance to my health care agent & doctors.

In working together to make treatment decisions and plans for my care, please consider my general preferences described below:

CHOOSE **ONE** BOX ONLY

☐ I am not sure at this time which statements below I most agree with. I trust my health care agent to do what is best for me.

☐ I want to continue living even if my quality of life seems low to others and I am unable to communicate with people. In general, I would accept support of my breathing, heart, and kidney function by machines that require me to be in a hospital or special care unit.

☐ Life is precious, but I understand that we all die sometime. I want to live as long as I can interact with others and can enjoy some quality of life. I would accept intensive treatments only if I had a reasonable chance of getting better. I would refuse long-term support by intensive medications or machines if my quality of life was poor and I was not able to communicate with people.

☐ It is most important to me to avoid suffering. I do not want extraordinary medical treatments, such as breathing machines or cardiopulmonary resuscitation (CPR). If my natural body functions fail, I would refuse treatments and choose to die naturally.

Is there anything your doctors should know about you to provide you with the best care possible?

_____

_____

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 care decisions for myself.

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

PRIOR DESIGNATIONS REVOKED: I revoke any prior medical power attorney.

DISCLOSURE STATEMENT

THIS MEDICAL POWER OF ATTORNEY 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 unable to make the decisions for 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 is effective 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 if you were able to make health care decisions for yourself.

It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure 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 facility, or residential care facility, 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 allow a person to serve as 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 you intend to 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 make those decisions, 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 in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void.

This document may not be changed or modified. If you want to make changes in this document, you must execute a new medical power of attorney.

Name: _____ Date of Birth: _____

THIS POWER OF ATTORNEY IS NOT VALID UNLESS: (1) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES OR (2) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; 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 medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that I have read and understand the information contained in the above disclosure statement.

Step 3: Complete and sign the form in front of <u>EITHER</u> 1) two witnesses OR 2) notary public

Signature _____ Date:_____

Address: _____

Option 1 - Two Witnesses

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of Texas that:

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

Signature _____

Name:_____

Address: _____

Date:_____

Signature _____

Name :_____

Address:_____

Date:_____

Name: _____ Date of Birth: _____

Option 2 - Notary

SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this medical power of attorney on _____

(City and State)

(Signature)

State of Texas County of

_____

(Print Name)

This instrument was acknowledged before me on (name of person acknowledging).

(_____) by

NOTARY PUBLIC, State of Texas

Name: _____ Date of Birth: _____

