

SUGGESTIONS & REQUIREMENTS

For Medical Power of Attorney & Completing the Texas Will to Live Form

1. This Medical Power of Attorney (also known as the Health Care Agent Designation Form) allows you to designate a health care agent who will make health care decisions for you whenever you are unable to make them for yourself; these forms allow you to direct your medical care through your health care agent. Any person who is at least 18 years old may designate a health care agent through this document.
2. Carefully read the “Information Concerning the Medical Power of Attorney.” Sign and date the form to show you have done so. This form explains the witnessing requirements and eligibility restrictions for your health care agent.
3. You must sign this Medical Power of Attorney in the presence of two witnesses who must also sign the document. Each witness must be a competent adult, and at least one of the witnesses must be a person who is NOT one of the following:
 - a. the person you have designated as your health care agent,
 - b. a person related to you by blood or marriage,
 - c. 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,
 - d. your attending physician,
 - e. an employee of your attending physician,
 - f. an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you,
 - g. an officer, director, partner, or business office employee of the health care facility or parent organization of the health care facility providing care to you, or
 - h. 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.
4. You may not appoint your physician, residential care provider, or an employee of your physician or residential care provider as your health care agent unless that person is your relative.
5. An alternate health care agent(s) should be designated who can take over if your first designee is unable to serve. Space is provided on the form for this alternate designation. The same rules apply to the alternate health care agent as for the primary health care agent.
6. If you physically cannot sign this document, another person may sign your name for you at your express direction in your presence and in the presence of your two witnesses.
7. Tell your doctor and your attorney about this document. Also ask your doctor to keep a copy of this document as a part of your medical health record. Your attorney may wish to keep a copy also.
8. This type of document has been authorized by the “Advance Directives Act” of the Texas Health and Safety Code, §§166.001 through 166.010 and §§166.151 through 166.166.
9. If you have any questions about this document, or want assistance in completing it, please consult an attorney. Texas Right to Life can offer referrals to attorneys.

Information Concerning the Medical Power of Attorney and the Texas Will to Live

THIS IS AN IMPORTANT LEGAL DOCUMENT.

BEFORE SIGNING THIS DOCUMENT, LEARN THE FOLLOWING IMPORTANT FACTS.

Except to the extent you state otherwise, this document authorizes the person you name as your health care agent to make any and all health care decisions for you in accordance with your advance instructions when you can no longer make such decisions for yourself. These instructions should incorporate your religious and moral beliefs. Because “health care” means any treatment, service, or procedure to maintain, diagnose or treat your physical or mental condition, your health care agent has the power to make a broad range of health care decisions for you. Your health care agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your health care agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion.

Texas law allows for a physician or hospital to withdraw life-sustaining treatment (including food and water) from you despite your expressed instructions in a validly executed advance directive or medical power of attorney. Once the decision to withdraw treatment and/or food and fluids is made by your physician, the decision will then be validated by an ethics committee at the hospital where you are being treated. At that time, you, your health care agent, and/or your family have only ten (10) days to locate and transfer to another facility willing to provide the necessary life-sustaining medical treatment. The physician or facility is not obligated to treat you beyond the tenth day, which could lead to your death. Rarely are transfers effectuated either by the family or the facility within the ten-day allotment. However, if your instructions are written and clearly expressed in a “Medical Power of Attorney” accompanied by a completed “Will to Live” document, your health care agent will be in a better position to defend your life in the event he/she needs to go to court to protect your life from the withdrawal or denial of medical treatment and/or food and fluids.

Your health care agent’s authority begins when your doctor certifies that you lack the competence to make health care decisions. Your health care agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your health care agent has the same authority to make decisions about your health care that you would have if you were competent.

Your instructions and this document should be discussed with your health care agent, physician, other health care provider(s) if any, and your family before you sign it, thereby ensuring that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, consult 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 that you do not understand in this document, consult an attorney.

The person you appoint as your health care 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 legally 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 health care agent or acting as your health or residential care provider; the law does not permit a person to do both at the same time.

Inform the person who you appoint that you want the person to be your health care agent. Discuss your instructions and this document with your health care agent in addition to your physician and give each a signed copy. The document itself should indicate the institutions and people who are in possession of signed copies.

Your health care 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. You have the right to revoke the authority granted to your health care agent by informing your health care agent or your health or residential care provider orally or in writing or by 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 health care agent in the event that your health care agent is unwilling, unable, or ineligible to act as your health care agent. Any alternate health care agent you designate has the same authority to make health care decisions for you.

THIS MEDICAL POWER OF ATTORNEY IS NOT VALID UNLESS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. AT LEAST ONE OF THE WITNESSES MUST BE A PERSON WHO IS NOT ONE OF THE FOLLOWING:

- a) the person you have designated as your health care agent,
- b) a person related to you by blood or marriage,
- c) 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,
- d) your attending physician,
- e) an employee of your attending physician,
- f) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you,
- g) an officer, director, partner, or business office employee of the health care facility or parent organization of the health care facility providing care to you, or
- h) 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.

I have read and understood the contents of this disclosure statement.

(signature) _____

(date) _____

**MEDICAL POWER OF ATTORNEY
and TEXAS WILL TO LIVE**

I, (your name) _____

(your address) _____

(your phone number) _____

appoint:

(name of health care agent) _____

(address of health care agent) _____

(phone number(s) of health care agent) _____

as my health care agent to make any and all health care 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 HEALTH CARE AGENT FOLLOW.

GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and health care agent(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment but basic necessities. I direct my health care provider(s) and health care agent to provide me with food and fluids orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to contribute to, hasten, or cause my death. I direct that the following be provided to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions:

- a) the administration of medication,
- b) cardiopulmonary resuscitation (CPR), and
- c) the performance of all other medical procedures, techniques, and technologies, including surgery.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy.

I also reject any treatments that use an organ or tissue of another person, including stem cells extracted from human embryos, or stem cells obtained in a manner that causes, contributes to, or hastens that person's death.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the "quality" of my life. I reject any action or omission that is intended to cause or hasten my death. I direct my health care provider(s) and health care agent to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my health care agent, as named above, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

WHEN MY DEATH IS IMMINENT

A. If a reasonably prudent physician, knowledgeable about my case and treatment possibilities with respect to the medical conditions involved, would judge that I have an incurable terminal illness or injury, and I will die imminently even if lifesaving treatment or care is provided to me, the following may be withheld or withdrawn:

(Be as specific as possible.)

(Cross off any remaining blank lines.)

WHEN I AM TERMINALLY ILL

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury, and even though death is not imminent, I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about my case and treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me the following may be withheld or withdrawn:

(Be as specific as possible.)

(Cross off any remaining blank lines.)

C. OTHER SPECIAL CONDITIONS

(Be as specific as possible.)

(Cross off any remaining blank lines.)

IF I AM PREGNANT

D. Special Instructions for Pregnancy.

If I am pregnant, I direct my health care provider(s) and health care agent(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even if I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

Signature of Declarant

DESIGNATION OF ALTERNATE HEALTH CARE AGENT

(You are not required to designate an alternate health care agent, but doing so can be helpful. An alternate health care agent may make the same health care decisions as the designated health care agent if the designated health care agent is unable or unwilling to act as your health care agent. If the health care agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

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

A. First Alternate Health Care Agent

(Name) _____

(Address) _____

(Phone Number) _____

B. Second Alternate Health Care Agent

(Name) _____

(Address) _____

(Phone Number) _____

The original of this document is kept at the following location:

The following individuals or institutions are in possession of additional signed copies:

Name _____

Address _____

Name _____

Address _____

DURATION

I understand that this Medical Power of Attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke this Medical Power of Attorney. If I am unable to make health care decisions for myself when this document expires, the authority granted to my health care agent lasts until the time I become able to make health care decisions for myself. (IF APPLICABLE) This Medical Power of Attorney ends on the following date:

PRIOR DESIGNATIONS REVOKED

I revoke any prior Medical Powers of Attorney and Health Care Agent Designations.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT

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

(YOU MUST DATE AND SIGN THIS MEDICAL POWER OF ATTORNEY.)

I Sign My Name to this Medical Power of Attorney on

this _____ Day of _____, 20_____

at _____ (City, State).

(Your Signature)_____

(Your Printed Name)_____

STATEMENT OF WITNESSES

I am not the person appointed as health care 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. Furthermore, 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.

First Witness Signature: _____

Name: _____

Date: _____

Residential Address: _____

Second Witness Signature: _____

Name: _____

Date: _____

Residential Address: _____