

# MEDICAL POWER OF ATTORNEY

## DESIGNATION OF HEALTH CARE AGENT

I, \_\_\_\_\_ (insert your name), appoint:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

as my 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 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 unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved, annulled, or declared void unless this document provides otherwise.)

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c

The following individuals or institutions have signed copies:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

**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 of 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.

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

**(YOUR MUST SIGN AND DATE THIS POWER OF ATTORNEY AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)**

I sign my name to this medical power of attorney on \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ (month, year) at \_\_\_\_\_.  
(City and State)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Print Name)

STATE OF TEXAS  
COUNTY OF \_\_\_\_\_

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Subscribed and sworn to before me by the said \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public, State of Texas  
Printed Name: \_\_\_\_\_  
My Commission Expires: \_\_\_\_\_