

Medical Power of Attorney

(Texas Health & Safety Code Annotated §§ 166.001 to 166.166)

DISCLOSURE STATEMENT

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 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.

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 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:

- (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.

THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

- (1) the person you have designated as your health-care agent or alternate 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.

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1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint a health-care agent in case of my incapacity.
2. I am one of Jehovah's Witnesses, and I direct that **NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma** be given me under any circumstances, even if health-care providers believe that such are necessary to preserve my life. (Acts 15:28, 29) I refuse to predonate and store my blood for later infusion.
3. **Regarding end-of-life matters:** [initial one of the two choices]
 - (a) _____. I do not want my life to be prolonged if, to a reasonable degree of medical certainty, my situation is hopeless.
 - (b) _____. I want my life to be prolonged as long as possible within the limits of generally accepted medical standards, even if this means that I might be kept alive on machines for years.
4. **Regarding other health-care instructions** (such as current medications, allergies, medical problems, or any other comments about my health-care wishes), I direct that:

5. I give no one (including my agent) any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions.
6. Apart from the matters covered above, I appoint the person named herein as my agent to make health-care decisions for me. I give my agent full power and authority to consent to or to refuse treatment (including artificial nutrition and hydration) on my behalf, to consult with my doctors and receive copies of my medical records, and to take legal action to ensure that my wishes are honored. If my first appointed agent is unavailable, unable, or unwilling to serve, I appoint an alternate agent herein to serve with the same power and authority.
7. **Regarding health-care decisions during pregnancy [if applicable]:** I direct that my health-care provider and my health-care agent fully honor my refusal of blood transfusions even if I am pregnant. In the event of my incapacity, my health-care agent has the authority to make health-care decisions for me even while I am pregnant.

8. I have been provided with a disclosure statement (pages 1 and 2) explaining the effect of this document. I have read and understand the information contained in the disclosure statement. I sign my name to this Medical Power of Attorney on the date indicated below.

(Signature*)

(Date)

(Address)

THIS DOCUMENT MUST BE SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. HOWEVER, ONLY THE FIRST WITNESS MUST COMPLY WITH THE FOLLOWING STATEMENT:

STATEMENT OF FIRST WITNESS

I am not the person appointed as health-care agent or alternate agent by this document. I am not related to the principal (the person who signed above) 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.

(Signature of first witness / Date)

(Signature of second witness / Date)

(Address)

(Address)

HEALTH-CARE AGENT*

Name: _____

Address: _____

Telephone(s): _____

* **Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your health-care agents). You should sign this document in the presence of two witnesses. You may appoint any adult as your agent except (1) your health-care provider, (2) a nonrelative employee of your health-care provider, (3) your residential-care provider, or (4) a nonrelative employee of your residential-care provider. A "nonrelative" is a person not related to you by blood, marriage, or adoption.

ALTERNATE HEALTH-CARE AGENT*

Name: _____

Address: _____

Telephone(s): _____

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(signed document inside)

NO BLOOD

