CONCERNING YOUR

MEDICAL POWER OF ATTORNEY

DISCLOSURE 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 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 (such as shock 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.

It is important to 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.

Many people find that what is acceptable or suitable changes with experience. One caregiving organization found that roughly half of people with advanced chronic conditions changed their minds within two years. You should review your Medical Power of Attorney from time to time and replace it if you want to name another agent or change your agent's powers.

If you have an Advanced Directive, you should also review that from time to time to make sure it reflects your preferences.

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.

Your agent should be able to answer four questions:

1. *Will it benefit you? What is the chance that it will?*
2. *What is the possible harm or burden? What is the chance of that harm? Would you be willing to accept it if you could communicate?*
3. *Is there hope of recovery? What is the possibility? If you recovered, what would life be like for you afterwards?*
4. *What are your values? What are your goals for your care?*

You should ask the person whom you want to appoint whether they can answer those questions and whether they want to be your health care agent.

In determining your wishes, that person is required to consider

(i) your current diagnosis and prognosis with the treatment at issue;

(ii) your expressed preferences with regard to the provision or the withholding of the specific treatment at issue or of similar treatment;

(iii) your relevant religious and moral beliefs and personal values;

(iv) your behavior, attitudes and past conduct with regard to the treatment in question and with regard to medical treatment generally;

(v) your reactions to the provision or the withholding or withdrawal of a similar treatment for another individual; and

(vi) your expressed concerns about the effect on your family and intimate friends if a treatment were provided or withheld or withdrawn.

You should discuss this document with your agent and physician and give each

- *a signed copy of this Medical Power of Attorney,*
- *a signed copy of your Advance Directive,*
- *a copy of your HIPAA Medical Information Release and*
- *a signed copy of any Do Not Hospitalize or Do Not Resuscitate Order.*

You should indicate on this Medical Power of Attorney the people and institutions which have signed copies.

Note that 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 unless your doctor certifies that you are unable to do so. Treatment cannot be 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 executing 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 this 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 MEDICAL POWER OF ATTORNEY IS NOT VALID UNLESS YOU

SIGN IT AND ACKNOWLEDGE IT BEFORE A NOTARY PUBLIC

OR

YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT WITNESSES.

THE FOLLOWING PERSONS MAY NOT BE A WITNESS:

(1) the person you have named as your agent or substitute agent;

(2) a person related to your 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 signed, has a claim against any part of your estate after your death.

In addition to this Medical Power of Attorney, Texas law provides for two other types of directives that can be important during a serious illness. These are the Directive to Physicians and Family or Surrogates ("Advance Directive") and Out-of-Hospital Do-Not-Resuscitate Order.. You can also arrange to donate your organs and tissues through another directive, found at www.shareyourlife.org, your corneas through the Lion's Club, your brain to a Brain Bank or, if you live in Central Texas, make a full body donation to UTSA.

I CERTIFY THAT I HAVE READ THE FOREGOING DISCLOSURE STATEMENT CONCERNING THE MEDICAL POWER OF ATTORNEY AND UNDERSTAND ITS CONTENTS.

Date:_____, at _____, _____ County, Texas.

By_____

Printed Name:_____

MEDICAL POWER OF ATTORNEY

DESIGNATION OF HEALTH CARE AGENT

I, _____, appoint

Name _____

Address _____

_____

Telephone _____

E-mail _____

my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document.

If that person 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.

As my first alternative	As my second alternative
Name _____	Name_____
Address_____	Address_____
_____	_____
Telephone _____	Telephone_____
E-mail_____	E-mail_____

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.

(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.)

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 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 myself.

PRIOR DESIGNATIONS REVOKED: I revoke any prior Medical Power of Attorney.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT.

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.

(YOU MUST DATE AND SIGN THIS MEDICAL 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.)

SIGNATURE ACKNOWLEDGED BEFORE A NOTARY:

I sign my name to this Medical Power of Attorney on the _____ day of _____ at _____, Texas.

_____

Printed Name_____

STATE OF TEXAS

COUNTY OF _____

This Medical Power of Attorney was executed before me on the ___ date of _____ by _____.

_____

NOTARY PUBLIC, State of Texas

_____

Printed Name

MEDICAL POWER OF ATTORNEY:

DESIGNATION OF HEALTH CARE AGENT

STATEMENT OF FIRST WITNESS

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. 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_____ Date_____

Name_____

Address_____

_____

SIGNATURE OF SECOND WITNESS

Signature_____ Date_____

Name_____

Address_____

_____