

~ Texas ~

Medical Power of Attorney Christian Version

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 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.

STATE OF TEXAS MEDICAL POWER OF ATTORNEY

Written in accordance with Texas Advance Directives Act § 166.164 (Health and Safety Code)

MEDICAL POWER OF ATTORNEY DESIGNATION OF AGENT

I, _____ appoint:
Insert your name

Name: _____ Phone: (_____) _____

Address: _____

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.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state (add more items as appropriate):

1. I request that the attached Addendum (pages 7-14) be included as a valid part of this Medical Power of Attorney document.

2. I request, but not as a requirement, that my agent consult my clergy regarding health care decisions.

3. _____

[Attach additional pages, if needed]

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.)

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:

First Alternate Agent

Name: _____ Phone: (_____) _____

Address: _____

Second Alternate Agent

Name: _____ Phone: (_____) _____

Address: _____

The original of this document is kept at: _____

The following individuals or institutions have signed copies:

Name: _____ Phone: (_____) _____

Address: _____

Name: _____ Phone: (_____) _____

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.

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 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 NOTARY

I sign my name to this medical power of attorney on _____ day of _____ at
Date Month, Year

(City and State)

(Signature)

(Print Name)

State of Texas

County of _____

This instrument was acknowledged before me on _____ by
Date

(Name of Person Acknowledging)

NOTARY PUBLIC, State of Texas

Notary's printed name: _____

My commission expires: _____

----- OR -----

SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

I sign my name to this Medical Power of Attorney – Christian Version on _____ day of _____,
Date Month

Year

City

State

Zip

Signature: _____

Print name: _____

Texas

STATEMENT OF FIRST WITNESS

I am not the person appointed as an agent in 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:** _____

Print name: _____

Address: _____

SIGNATURE OF SECOND WITNESS

Signature: _____ **Date:** _____

Print name: _____

Address: _____

ADDENDUM TO THE STATE OF TEXAS MEDICAL POWER OF ATTORNEY

GENERAL STATEMENT OF AUTHORITY GRANTED

As the declarant of this document, I desire to have my health care decisions made in accordance with this Addendum to the Medical Power of Attorney – Christian Version. The purposes of this Addendum are to provide a witness to my Christian belief that life is a gift from God, and to provide direction for my agent to make decisions that are consistent with my Christian faith.

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my agent and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my agent under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my agent is instructed to make the health care decision for me, but my agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my agent shall base his or her health care decision on what he or she believes to be in my best interest.

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief in the inherent value of human life and that life is a gift from God. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my agent to consent to the following health care:
 - a. Health care that is intended to relieve pain or to make me comfortable.
 - b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.
2. My agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my agent to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.
4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God’s time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.
5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My agent may refuse consent to health care that would not be effective in terms of my survival.
2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.
3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my agent may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.
4. If I have a total, chronic and irreversible loss of consciousness, this condition must be diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition. Upon such diagnosis, my agent may consent to the withholding or withdrawal of certain life–sustaining health care, remaining faithful to the directives found in the rest of this document. I still desire health care for easily treatable acute and chronic conditions and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.
2. If I check “Yes” to the “Withhold or withdraw a feeding tube” option in the next section, then a feeding tube may only be withheld or withdrawn from me if:
 - a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
 - b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

PROVISION OF FEEDING TUBE

If I have checked “Yes” to the following, my agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked “No” to the following, my agent may not have a feeding tube withheld or withdrawn from me.

My agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes** **No**

If I have not checked either “Yes” or “No” immediately above, my agent may not have a feeding tube withheld or withdrawn from me.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.
2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.
3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.
4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.
5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

PROVISION FOR PREGNANT WOMEN

If I have checked “Yes” to the following, my agent may make health care decisions for me if he/she knows I am pregnant. If I have checked “No” to the following, my agent may not make health care decisions for me if he/she knows I am pregnant.

Health care decision if I am pregnant **Yes** **No**

If I have not checked either “Yes” or “No” immediately above, my agent may not make health care decisions for me if he or she knows I am pregnant.

In no event is my agent authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My agent may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My agent may not consent to experimental mental health research or psycho surgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my agent has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.
2. Execute on my behalf any documents that may be required in order to obtain this information.
3. Consent to the disclosure of this information.

HIPAA RELEASE STATEMENT

I intend for my agent to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my agent the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

ADMISSION TO NURSING HOMES

My agent may admit me to a nursing home for short-term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my agent may not so admit me:

A nursing home **Yes** **No**

If I have not checked either "Yes" or "No" immediately above, my agent may only admit me for short-term stays for recuperative care or respite care.

ANATOMICAL GIFTS

Optional

Upon my death:

_____ I wish to donate only the following organs or parts:

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: _____ **Date:** _____

The principal's signature must be witnessed at the same time by two adult witnesses or a notary public.

STATEMENT OF PRINCIPAL
(Person creating this Medical Power of Attorney)

I have read this addendum to the Texas Medical Power of Attorney – Christian Version. I understand that it allows another person to make life and death decisions for me if I am incapable of making such decisions. I also understand that I can revoke this Medical Power of Attorney and Addendum at any time by notifying my agent, my physician, or the facility in which I am a patient or resident.

I sign my name to this Medical Power of Attorney – Christian Version on _____ day of _____,
Date Month
_____ at _____, _____
Year City State

Signature: _____

Print name: _____

STATEMENT OF ADULT WITNESSES

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.

Witness #1

Signature: _____ **Date:** _____

Print name: _____

Address: _____

Witness #2

Signature: _____ **Date:** _____

Print name: _____

Address: _____

----- **OR** -----

SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this medical power of attorney on _____ day of _____ at
Date Month, Year

(City and State)

(Signature)

(Print Name)

State of Texas

County of _____

This instrument was acknowledged before me on _____ by
Date

(Name of Person Acknowledging)

NOTARY PUBLIC, State of Texas

Notary's printed name: _____

My commission expires: _____

STATEMENT OF AGENT

I understand that _____ has designated me to be his or her agent if he or she
is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

Name of principal

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Agent's signature: _____

Address: _____

STATEMENT OF ALTERNATE AGENTS

I understand that _____ has designated me to be his or her alternate
agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the
person designated as agent is unable or unwilling to make those decisions.

Name of principal

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

First alternate agent's signature: _____

Address: _____

Second alternate agent's signature: _____

Address: _____

CLERGY *Optional*

Clergy's signature: _____

Church name: _____ Phone: (_____) _____

Church Address: _____

I have given copies of this Medical Power of Attorney – Christian Version to:

