By: Howard H.B. No. 2589

A BILL TO BE ENTITLED

AN ACT

relating to the form of a medical power of attorney.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter D, Chapter 166, Health and Safety Code, is amended by adding Section 166.163 to read as follows:

Sec. 166.163. PERMISSIBLE FORMS OF MEDICAL POWER OF ATTORNEY. A medical power of attorney may be in a form:

(1) authorized under Section 166.005;

(2) described by Section 166.164; or

(3) that:

(A) meets the requirements of this subchapter, including execution in accordance with Section 166.154;

(B) is in writing;

(C) designates an agent; and

(D) contains:

(i) the principal's name; and

(ii) the date the medical power of attorney is executed.

SECTION 2. Section 166.164, Health and Safety Code, is amended to read as follows:

Sec. 166.164. FORM OF MEDICAL POWER OF ATTORNEY. A [~~The~~] medical power of attorney may [~~must~~] be in [~~substantially~~] the following form:

MEDICAL POWER OF ATTORNEY DESIGNATION OF HEALTH CARE AGENT.

1 I, ___________ (insert your name) appoint:

2 Name:____

3 Address:____

4 Phone:____

5 as my agent to make any and all health care decisions for me,
6 except to the extent I state otherwise in this document. This
7 medical power of attorney takes effect if I become unable to make my
8 own health care decisions and this fact is certified in writing by
9 my physician.

10 LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE
11 AS FOLLOWS: ____

12 ____

13 DESIGNATION OF ALTERNATE AGENT.

14 (You are not required to designate an alternate agent but you
15 may do so. An alternate agent may make the same health care
16 decisions as the designated agent if the designated agent is unable
17 or unwilling to act as your agent. If the agent designated is your
18 spouse, the designation is automatically revoked by law if your
19 marriage is dissolved, annulled, or declared void unless this
20 document provides otherwise.)

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

25 A. First Alternate Agent

26 Name:____

27 Address:____

1 Phone: ______________________________

2 B. Second Alternate Agent

3 Name:______________________________

4 Address:______________________________

5 Phone: ______________________________

6 The original of this document is kept at:

7 ______________________________

8 ______________________________

9 ______________________________

10 The following individuals or institutions have signed

11 copies:

12 Name:______________________________

13 Address:______________________________

14 ______________________________

15 Name:______________________________

16 Address:______________________________

17 ______________________________

18 DURATION.

19 I understand that this power of attorney exists indefinitely

20 from the date I execute this document unless I establish a shorter

21 time or revoke the power of attorney. If I am unable to make health

22 care decisions for myself when this power of attorney expires, the

23 authority I have granted my agent continues to exist until the time

24 I become able to make health care decisions for myself.

25 (IF APPLICABLE) This power of attorney ends on the following

26 date: ___________

27 PRIOR DESIGNATIONS REVOKED.

1 I revoke any prior medical power of attorney.

2 DISCLOSURE STATEMENT.

3 THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL
4 DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE
5 IMPORTANT FACTS:

6 Except to the extent you state otherwise, this document gives
7 the person you name as your agent the authority to make any and all
8 health care decisions for you in accordance with your wishes,
9 including your religious and moral beliefs, when you are unable to
10 make the decisions for yourself. Because "health care" means any
11 treatment, service, or procedure to maintain, diagnose, or treat
12 your physical or mental condition, your agent has the power to make
13 a broad range of health care decisions for you. Your agent may
14 consent, refuse to consent, or withdraw consent to medical
15 treatment and may make decisions about withdrawing or withholding
16 life-sustaining treatment. Your agent may not consent to voluntary
17 inpatient mental health services, convulsive treatment,
18 psychosurgery, or abortion. A physician must comply with your
19 agent's instructions or allow you to be transferred to another
20 physician.

21 Your agent's authority is effective when your doctor
22 certifies that you lack the competence to make health care
23 decisions.

24 Your agent is obligated to follow your instructions when
25 making decisions on your behalf. Unless you state otherwise, your
26 agent has the same authority to make decisions about your health
27 care as you would have if you were able to make health care

1 decisions for yourself.
2 It is important that you discuss this document with your
3 physician or other health care provider before you sign the
4 document to ensure that you understand the nature and range of
5 decisions that may be made on your behalf. If you do not have a
6 physician, you should talk with someone else who is knowledgeable
7 about these issues and can answer your questions. You do not need a
8 lawyer's assistance to complete this document, but if there is
9 anything in this document that you do not understand, you should ask
10 a lawyer to explain it to you.
11 The person you appoint as agent should be someone you know and
12 trust. The person must be 18 years of age or older or a person under
13 18 years of age who has had the disabilities of minority removed.
14 If you appoint your health or residential care provider (e.g., your
15 physician or an employee of a home health agency, hospital, nursing
16 facility, or residential care facility, other than a relative),
17 that person has to choose between acting as your agent or as your
18 health or residential care provider; the law does not allow a person
19 to serve as both at the same time.
20 You should inform the person you appoint that you want the
21 person to be your health care agent. You should discuss this
22 document with your agent and your physician and give each a signed
23 copy. You should indicate on the document itself the people and
24 institutions that you intend to have signed copies. Your agent is
25 not liable for health care decisions made in good faith on your
26 behalf.
27 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.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. If you designate an alternate agent, the alternate agent has the same authority as the agent 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 medical power of attorney is executed, has a claim against any part of your estate after your death.

By signing below, I acknowledge that I have read and understand the information contained in the above 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 ___________ (month, year) at

____

(City and State)

____

(Signature)

____

(Print Name)

State of Texas

County of _________

This instrument was acknowledged before me on ___________ (date) by

__________________ (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 on ___________ day of ___________ (month, year) at

____

(City and State)

____

(Signature)

____

(Print Name)

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,

1 director, partner, or business office employee of the health care
2 facility or of any parent organization of the health care facility.
3 Signature:____
4 Print Name:_________________________________ Date: _______
5 Address:____
6 SIGNATURE OF SECOND WITNESS.
7 Signature:____
8 Print Name:_________________________________ Date: _______
9 Address:____
10 SECTION 3. Not later than December 1, 2023, the executive
11 commissioner of the Health and Human Services Commission shall
12 adopt the rules necessary to implement the changes in law made by
13 this Act.
14 SECTION 4. The changes in law made by this Act apply only to
15 a medical power of attorney executed on or after the effective date
16 of this Act. A medical power of attorney executed before the
17 effective date of this Act is governed by the law in effect
18 immediately before the effective date of this Act, and the former
19 law is continued in effect for that purpose.
20 SECTION 5. This Act takes effect September 1, 2023.