

By: Bhojani

H.B. No. 1059

A BILL TO BE ENTITLED

AN ACT

relating to the presumption of validity for an advance directive and permissible forms of a medical power of attorney.

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

SECTION 1. Subchapter A, Chapter 166, Health and Safety Code, is amended by adding Section 166.012 to read as follows:

Sec. 166.012. PRESUMPTION OF VALIDITY; LIMITATION OF LIABILITY. (a) In the absence of actual knowledge to the contrary, a health care provider or residential care provider, as those terms are defined by Section 166.151, or other person acting as an agent for or under the provider's control may presume an advance directive is valid under this chapter and has been validly executed by a person authorized to execute the advance directive.

(b) The health care provider, residential care provider, or other person described by Subsection (a) is not civilly or criminally liable or subject to review or disciplinary action by the appropriate licensing authority for following an advance directive or instructions of an advance directive the provider or person presumes is valid under this chapter.

SECTION 2. 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) A valid medical power of attorney must be in:

(1) a form the executive commissioner designates in

1 accordance with Subsection (b), provided the document is executed  
2 in the manner required by Section 166.154; or

3 (2) the statutory form prescribed by Section 166.164.

4 (b) The executive commissioner by rule shall review and  
5 designate documents to be recognized in this state as a written and  
6 validly executed medical power of attorney. Any document the  
7 executive commissioner designates must:

8 (1) be promulgated by a national nonprofit  
9 organization or the American Bar Association Commission on Law and  
10 Aging;

11 (2) be written in plain language;

12 (3) allow a principal to provide a health care  
13 instruction;

14 (4) designate a primary agent who is at least 18 years  
15 of age to make health care decisions for the principal when the  
16 principal lacks the capacity to make the decisions;

17 (5) allow the principal to name an alternate agent who  
18 is at least 18 years of age to make health care decisions for the  
19 principal if the primary agent is unable or unwilling to make the  
20 decisions;

21 (6) allow the principal to specify or limit the health  
22 care decisions an agent may make for the principal;

23 (7) require the principal to:

24 (A) sign and date the medical power of attorney  
25 in the presence of two witnesses who qualify under Section 166.003,  
26 at least one of whom qualifies under Section 166.003(2); or

27 (B) sign and date the medical power of attorney

1 and have the signature acknowledged before a notary public; and  
2 (8) be accepted as a validly executed medical power of  
3 attorney in at least 40 other states of the United States.

4 (c) The commission shall post on the commission's Internet  
5 website a link to each document designated under Subsection (b).

6 SECTION 3. Section 166.164, Health and Safety Code, is  
7 amended to read as follows:

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

11 MEDICAL POWER OF ATTORNEY DESIGNATION OF HEALTH CARE AGENT.  
12 I, \_\_\_\_\_ (insert your name) appoint:  
13 Name: \_\_\_\_\_  
14 Address: \_\_\_\_\_  
15 Phone: \_\_\_\_\_

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

21 LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE  
22 AS FOLLOWS: \_\_\_\_\_  
23 \_\_\_\_\_

24 DESIGNATION OF ALTERNATE AGENT.  
25 (You are not required to designate an alternate agent but you  
26 may do so. An alternate agent may make the same health care  
27 decisions as the designated agent if the designated agent is unable

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

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

9 A. First Alternate Agent

10 Name: \_\_\_\_\_  
11 Address: \_\_\_\_\_  
12 Phone: \_\_\_\_\_

13 B. Second Alternate Agent

14 Name: \_\_\_\_\_  
15 Address: \_\_\_\_\_  
16 Phone: \_\_\_\_\_

17 The original of this document is kept at:  
18 \_\_\_\_\_  
19 \_\_\_\_\_  
20 \_\_\_\_\_

21 The following individuals or institutions have signed  
22 copies:

23 Name: \_\_\_\_\_  
24 Address: \_\_\_\_\_  
25 \_\_\_\_\_

26 Name: \_\_\_\_\_  
27 Address: \_\_\_\_\_

1 \_\_\_\_\_

2 DURATION.

3 I understand that this power of attorney exists indefinitely  
4 from the date I execute this document unless I establish a shorter  
5 time or revoke the power of attorney. If I am unable to make health  
6 care decisions for myself when this power of attorney expires, the  
7 authority I have granted my agent continues to exist until the time  
8 I become able to make health care decisions for myself.

9 (IF APPLICABLE) This power of attorney ends on the following  
10 date: \_\_\_\_\_

11 PRIOR DESIGNATIONS REVOKED.

12 I revoke any prior medical power of attorney.

13 DISCLOSURE STATEMENT.

14 THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL  
15 DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE  
16 IMPORTANT FACTS:

17 Except to the extent you state otherwise, this document gives  
18 the person you name as your agent the authority to make any and all  
19 health care decisions for you in accordance with your wishes,  
20 including your religious and moral beliefs, when you are unable to  
21 make the decisions for yourself. Because "health care" means any  
22 treatment, service, or procedure to maintain, diagnose, or treat  
23 your physical or mental condition, your agent has the power to make  
24 a broad range of health care decisions for you. Your agent may  
25 consent, refuse to consent, or withdraw consent to medical  
26 treatment and may make decisions about withdrawing or withholding  
27 life-sustaining treatment. Your agent may not consent to

1 voluntary inpatient mental health services, convulsive treatment,  
2 psychosurgery, or abortion. A physician must comply with your  
3 agent's instructions or allow you to be transferred to another  
4 physician.

5 Your agent's authority is effective when your doctor  
6 certifies that you lack the competence to make health care  
7 decisions.

8 Your agent is obligated to follow your instructions when  
9 making decisions on your behalf. Unless you state otherwise, your  
10 agent has the same authority to make decisions about your health  
11 care as you would have if you were able to make health care  
12 decisions for yourself.

13 It is important that you discuss this document with your  
14 physician or other health care provider before you sign the  
15 document to ensure that you understand the nature and range of  
16 decisions that may be made on your behalf. If you do not have a  
17 physician, you should talk with someone else who is knowledgeable  
18 about these issues and can answer your questions. You do not need a  
19 lawyer's assistance to complete this document, but if there is  
20 anything in this document that you do not understand, you should ask  
21 a lawyer to explain it to you.

22 The person you appoint as agent should be someone you know and  
23 trust. The person must be 18 years of age or older or a person  
24 under 18 years of age who has had the disabilities of minority  
25 removed. If you appoint your health or residential care provider  
26 (e.g., your physician or an employee of a home health agency,  
27 hospital, nursing facility, or residential care facility, other

1 than a relative), that person has to choose between acting as your  
2 agent or as your health or residential care provider; the law does  
3 not allow a person to serve as both at the same time.

4         You should inform the person you appoint that you want the  
5 person to be your health care agent. You should discuss this  
6 document with your agent and your physician and give each a signed  
7 copy. You should indicate on the document itself the people and  
8 institutions that you intend to have signed copies. Your agent is  
9 not liable for health care decisions made in good faith on your  
10 behalf.

11         Once you have signed this document, you have the right to make  
12 health care decisions for yourself as long as you are able to make  
13 those decisions, and treatment cannot be given to you or stopped  
14 over your objection. You have the right to revoke the authority  
15 granted to your agent by informing your agent or your health or  
16 residential care provider orally or in writing or by your execution  
17 of a subsequent medical power of attorney. Unless you state  
18 otherwise in this document, your appointment of a spouse is revoked  
19 if your marriage is dissolved, annulled, or declared void.

20         This document may not be changed or modified. If you want to  
21 make changes in this document, you must execute a new medical power  
22 of attorney.

23         You may wish to designate an alternate agent in the event that  
24 your agent is unwilling, unable, or ineligible to act as your  
25 agent. If you designate an alternate agent, the alternate agent  
26 has the same authority as the agent to make health care decisions  
27 for you.

1 THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

2 (1) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED  
3 BEFORE A NOTARY PUBLIC; OR

4 (2) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT  
5 WITNESSES.

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

7 (1) the person you have designated as your agent;

8 (2) a person related to you by blood or marriage;

9 (3) a person entitled to any part of your estate after  
10 your death under a will or codicil executed by you or by operation  
11 of law;

12 (4) your attending physician;

13 (5) an employee of your attending physician;

14 (6) an employee of a health care facility in which you  
15 are a patient if the employee is providing direct patient care to  
16 you or is an officer, director, partner, or business office  
17 employee of the health care facility or of any parent organization  
18 of the health care facility; or

19 (7) a person who, at the time this medical power of  
20 attorney is executed, has a claim against any part of your estate  
21 after your death.

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

25 (YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN  
26 IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR  
27 YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)



1 SIGNATURE ACKNOWLEDGED BEFORE NOTARY

2 I sign my name to this medical power of attorney on \_\_\_\_\_

3 day of \_\_\_\_\_ (month, year) at

4 \_\_\_\_\_

5 (City and State)

6 \_\_\_\_\_

7 (Signature)

8 \_\_\_\_\_

9 (Print Name)

10 State of Texas

11 County of \_\_\_\_\_

12 This instrument was acknowledged before me on \_\_\_\_\_ (date) by

13 \_\_\_\_\_ (name of person acknowledging).

14 \_\_\_\_\_

15 NOTARY PUBLIC, State of Texas

16 Notary's printed name:

17 \_\_\_\_\_

18 My commission expires:

19 \_\_\_\_\_

20 OR

21 SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

22 I sign my name to this medical power of attorney on \_\_\_\_\_

23 day of \_\_\_\_\_ (month, year) at

24 \_\_\_\_\_

25 (City and State)

26 \_\_\_\_\_

27 (Signature)

1 \_\_\_\_\_  
2 (Print Name)

3 STATEMENT OF FIRST WITNESS.

4 I am not the person appointed as agent by this document. I am  
5 not related to the principal by blood or marriage. I would not be  
6 entitled to any portion of the principal's estate on the principal's  
7 death. I am not the attending physician of the principal or an  
8 employee of the attending physician. I have no claim against any  
9 portion of the principal's estate on the principal's  
10 death. Furthermore, if I am an employee of a health care facility  
11 in which the principal is a patient, I am not involved in providing  
12 direct patient care to the principal and am not an officer,  
13 director, partner, or business office employee of the health care  
14 facility or of any parent organization of the health care facility.

15 Signature: \_\_\_\_\_

16 Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

18 SIGNATURE OF SECOND WITNESS.

19 Signature: \_\_\_\_\_

20 Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

22 SECTION 4. Not later than December 1, 2025, the executive  
23 commissioner of the Health and Human Services Commission shall by  
24 rule designate at least one document as required by Section  
25 166.163, Health and Safety Code, as added by this Act.

26 SECTION 5. Section 166.163, Health and Safety Code, as  
27 added by this Act, and Section 166.164, Health and Safety Code, as

1 amended by this Act, apply only to a medical power of attorney  
2 executed on or after the effective date of this Act. A medical  
3 power of attorney executed before the effective date of this Act is  
4 governed by the law in effect immediately before the effective date  
5 of this Act, and the former law is continued in effect for that  
6 purpose.

7 SECTION 6. This Act takes effect September 1, 2025.