

By: Thompson of Harris

H.B. No. 2124

A BILL TO BE ENTITLED

AN ACT

relating to a medical power of attorney.

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

SECTION 1. Sections 166.163 and 166.164, Health and Safety Code, are amended to read as follows:

Sec. 166.163. FORM OF DISCLOSURE STATEMENT. The disclosure statement must be in substantially the following form:

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

1 physician.

2 Your agent's authority begins when your doctor certifies that  
3 you lack the competence to make health care decisions.

4 Your agent is obligated to follow your instructions when  
5 making decisions on your behalf. Unless you state otherwise, your  
6 agent has the same authority to make decisions about your health  
7 care as you would have had.

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

17 The person you appoint as agent should be someone you know and  
18 trust. The person must be 18 years of age or older or a person under  
19 18 years of age who has had the disabilities of minority removed.  
20 If you appoint your health or residential care provider (e.g., your  
21 physician or an employee of a home health agency, hospital, nursing  
22 home, or residential care home, other than a relative), that person  
23 has to choose between acting as your agent or as your health or  
24 residential care provider; the law does not permit a person to do  
25 both at the same time.

26 You should inform the person you appoint that you want the  
27 person to be your health care agent. You should discuss this

1 document with your agent and your physician and give each a signed  
2 copy. You should indicate on the document itself the people and  
3 institutions who have signed copies. Your agent is not liable for  
4 health care decisions made in good faith on your behalf.

5 Even after you have signed this document, you have the right  
6 to make health care decisions for yourself as long as you are able  
7 to do so and treatment cannot be given to you or stopped over your  
8 objection. You have the right to revoke the authority granted to  
9 your agent by informing your agent or your health or residential  
10 care provider orally or in writing or by your execution of a  
11 subsequent medical power of attorney. Unless you state otherwise,  
12 your appointment of a spouse dissolves on divorce.

13 This document may not be changed or modified. If you want to  
14 make changes in the document, you must make an entirely new one.

15 You may wish to designate an alternate agent in the event that  
16 your agent is unwilling, unable, or ineligible to act as your agent.  
17 Any alternate agent you designate has the same authority to make  
18 health care decisions for you.

19 THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

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

22 (2) YOU SIGN IT [~~IS SIGNED~~] IN THE PRESENCE OF TWO  
23 COMPETENT ADULT WITNESSES.

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

- 25 (1) the person you have designated as your agent;  
26 (2) a person related to you by blood or marriage;  
27 (3) a person entitled to any part of your estate after

1 your death under a will or codicil executed by you or by operation  
2 of law;

3 (4) your attending physician;

4 (5) an employee of your attending physician;

5 (6) an employee of a health care facility in which you  
6 are a patient if the employee is providing direct patient care to  
7 you or is an officer, director, partner, or business office  
8 employee of the health care facility or of any parent organization  
9 of the health care facility; or

10 (7) a person who, at the time this power of attorney is  
11 executed, has a claim against any part of your estate after your  
12 death.

13 Sec. 166.164. FORM OF MEDICAL POWER OF ATTORNEY. The  
14 medical power of attorney must be in substantially the following  
15 form:

16 MEDICAL POWER OF ATTORNEY DESIGNATION OF HEALTH CARE AGENT.

17 I, \_\_\_\_\_ (insert your name) appoint:

18 Name: \_\_\_\_\_

19 Address: \_\_\_\_\_

20 Phone \_\_\_\_\_

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

26 LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE

27 AS FOLLOWS: \_\_\_\_\_

1 \_\_\_\_\_

2 DESIGNATION OF ALTERNATE AGENT.

3 (You are not required to designate an alternate agent but you  
4 may do so. An alternate agent may make the same health care  
5 decisions as the designated agent if the designated agent is unable  
6 or unwilling to act as your agent. If the agent designated is your  
7 spouse, the designation is automatically revoked by law if your  
8 marriage is dissolved.)

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

13 A. First Alternate Agent

14 Name: \_\_\_\_\_

15 Address: \_\_\_\_\_

16 Phone \_\_\_\_\_

17 B. Second Alternate Agent

18 Name: \_\_\_\_\_

19 Address: \_\_\_\_\_

20 Phone \_\_\_\_\_

21 The original of this document is kept at:

22 \_\_\_\_\_

23 \_\_\_\_\_

24 \_\_\_\_\_

25 The following individuals or institutions have signed  
26 copies:

27 Name: \_\_\_\_\_

1           Address:\_\_\_\_\_

2           \_\_\_\_\_

3           Name:\_\_\_\_\_

4           Address:\_\_\_\_\_

5           \_\_\_\_\_

6           DURATION.

7           I understand that this power of attorney exists indefinitely

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

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

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

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

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

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

14 date: \_\_\_\_\_

15           PRIOR DESIGNATIONS REVOKED.

16           I revoke any prior medical power of attorney.

17           ACKNOWLEDGMENT OF DISCLOSURE STATEMENT.

18           I have been provided with a disclosure statement explaining

19 the effect of this document. I have read and understand that

20 information contained in the disclosure statement.

21           (YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN

22 IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR

23 YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)

24           SIGNATURE ACKNOWLEDGED BEFORE NOTARY

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

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

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\_\_\_\_\_

(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.

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

12 Signature:\_\_\_\_\_

13 Print Name:\_\_\_\_\_ Date:\_\_\_\_\_

14 Address:\_\_\_\_\_

15 SIGNATURE OF SECOND WITNESS.

16 Signature:\_\_\_\_\_

17 Print Name:\_\_\_\_\_ Date:\_\_\_\_\_

18 Address:\_\_\_\_\_

19 SECTION 2. Not later than October 1, 2013, the executive  
20 commissioner of the Health and Human Services Commission shall  
21 adopt the forms necessary to comply with the changes in law made by  
22 this Act.

23 SECTION 3. The change in law made by this Act does not  
24 affect the validity of a document executed under Section 166.164,  
25 Health and Safety Code, before the effective date of this Act. A  
26 document executed before the effective date of this Act is governed  
27 by the law in effect on the date the document was executed, and that



1 law continues in effect for that purpose.

2 SECTION 4. (a) Except as provided by Subsection (b), this  
3 Act takes effect January 1, 2014.

4 (b) Section 2 of this Act takes effect September 1, 2013.