

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: _____

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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. Section 166.165, Health and Safety Code, is
20 amended by amending Subsections (a) and (c) and adding Subsection
21 (a-1) to read as follows:

22 (a) A person who is a near relative of the principal or a
23 responsible adult who is directly interested in the principal,
24 including a guardian, social worker, physician, or clergyman, may
25 bring an action [~~in district court~~] to request that the medical
26 power of attorney be revoked because the principal, at the time the
27 medical power of attorney was signed:

1 (1) was not competent; or

2 (2) was under duress, fraud, or undue influence.

3 (a-1) In a county in which there is no statutory probate
4 court, an action under this section shall be brought in the district
5 court. In a county in which there is a statutory probate court, the
6 statutory probate court and the district court have concurrent
7 jurisdiction over an action brought under this section.

8 (c) During the pendency of the action, the authority of the
9 agent to make health care decisions continues in effect unless the
10 [~~district~~] court orders otherwise.

11 SECTION 3. Not later than October 1, 2013, the executive
12 commissioner of the Health and Human Services Commission shall
13 adopt the forms necessary to comply with the changes in law made by
14 this Act to Sections 166.163 and 166.164, Health and Safety Code.

15 SECTION 4. The change in law made by this Act to Section
16 166.164, Health and Safety Code, does not affect the validity of a
17 document executed under that section before the effective date of
18 this section. A document executed before the effective date of this
19 section is governed by the law in effect on the date the document
20 was executed, and that law continues in effect for that purpose.

21 SECTION 5. The change in law made by this Act to Section
22 166.165, Health and Safety Code, applies to an action brought under
23 that section on or after the effective date of this Act, regardless
24 of whether the power of attorney was executed before, on, or after
25 the effective date of this Act.

26 SECTION 6. (a) Except as provided by Subsection (b) of
27 this section, this Act takes effect September 1, 2013.

1 (b) Sections 1 and 4 of this Act take effect January 1, 2014.

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 651 passed the Senate on April 25, 2013, by the following vote: Yeas 30, Nays 0.

Secretary of the Senate

I hereby certify that S.B. No. 651 passed the House on May 8, 2013, by the following vote: Yeas 146, Nays 1, two present not voting.

Chief Clerk of the House

Approved:

Date

Governor