# Directive to Physicians and Family or Surrogates

Advance Directives Act (see §166.033, Health and Safety Code)

This is an important legal document known as an Advance Directive. It is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. These wishes are usually based on personal values. In particular, you may want to consider what burdens or hardships of treatment you would be willing to accept for a particular amount of benefit obtained if you were seriously ill.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Your physician, other health care provider, or medical institution may provide you with various resources to assist you in completing your advance directive. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of the document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive, Texas law provides for two other types of directives that can be important during a serious illness. These are the Medical Power of Attorney and the Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss these with your physician, family, hospital representative, or other advisers. You may also wish to complete a directive related to the donation of organs and tissues.

## Directive

I _____, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

If, in the judgement of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care:

____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

____ I request that I be kept alive in this terminal condition using available life-sustaining treatment. **(This selection does not apply to Hospice care.)**

If, in the judgement of my physician, I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of medical care:

____ I request that all treatments other than those needed to keep me comfortable be discontinued or withheld and my physician allow me to die as gently as possible; OR

____ I request that I be kept alive in this irreversible condition using available life-sustaining treatment. **(This selection does not apply to Hospice care.)**

**Additional Requests:** (After discussion with your physician, you may wish to consider listing particular treatments in this space that you do or do not want in specific circumstances, such as artificial nutrition and fluids, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

_____

_____

After signing this directive, if my representative or I elect hospice care, I understand and agree that only those treatments needed to keep me comfortable would be provided and I would not be given available life-sustaining treatments.

If I do **not** have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make treatment decisions with my physician compatible with my personal values:

1._____

2._____

**(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)**

If the above persons are not available, or if I have not designated a spokesperson, I understand that a spokesperson will be chosen for me, following standards specified in the laws of Texas.

If, in the judgement of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I understand that under Texas law this directive has no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

Signed_____ Date_____

City, County and State of Residence_____

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*Two witnesses must sign in the spaces below*.

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as **Witness (1)** may not be a person designated to make a treatment decision for the patient and may not be related to the declarant by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness (1)_____ Witness (2)_____

# Disclosure Statement for Medical Power of Attorney

Advance Directives Act (see §166.163, Health and Safety Code)

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, 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 it is signed in the presence of two competent adult witnesses. The following persons may not act as ONE of the witnesses:

- the person you have designated as your agent.
- a person related to you by blood or marriage;
- 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;
- your attending physician;
- an employee of your attending physician;
- 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 a health care facility or of any parent organization of the health care facility; or
- a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

# Medical Power Of Attorney

Advance Directives Act (see §166.164, Health and Safety Code)

**Designation of Health Care Agent:**

I, _____ (insert your name) appoint:

Name: _____

Address: _____

_____ Phone: _____

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.

**Limitations On The Decision Making Authority Of My Agent Are As Follows:**

_____

_____

_____

_____

**Designation of an 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 person(s), 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: _____

Address: _____

_____ Phone: _____

Second Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

The original of the document is kept at _____

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

_____

Name: _____

Address: : _____

_____

(continued on reverse)

**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.

**Acknowledgement of Disclosure Statement**

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in this disclosure statement.

## (You Must Date and Sign This Power of Attorney)

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at

_____

(City and State)

_____

(Signature)

_____

(Print Name)

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**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, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: _____

Print Name: _____ Date: _____

Address: _____

_____

**Signature of Second Witness**

Signature: _____

Print Name: _____ Date: _____

Address: _____

_____

# Appointment of Agent to Control Disposition of Remains

This form is set out in Section 711.002 of the Texas Health and Safety Code. It is something to be considered, not only for the disposition of one's remains, but for funeral arrangements in general. It is especially important for couples living in non-traditional relationships. Very often the domestic partner will be shut out by the surviving family members of the decedent. It is important for any person who has serious concerns about his or her funeral arrangements to consider such an instrument. Although it looks like a power of attorney, it is not. Powers of attorney do not survive the principal. It is actually a contract, because the agent must sign on to the form, signifying his or her willingness to accept the appointment. It is extremely useful for persons who desire cremation, or who wish to donate their remains to a medical school for research. It can be employed to ensure that a favorite hymn or other musical piece be played at the funeral service. Once again, we remind you that that neither Texas Senior Law nor its sponsors can be held liable for any consequences of the use or misuse of this form. Merely providing this statutory form does not constitute legal advice, and no attorney-client relationship exists as a result of the furnishing of this form, absent a retainer contract with an attorney. You are advised to consult with your attorney or other advisor about the consequences of appointing an agent to control the disposition of your remains. It had better be someone in whom you have absolute faith.

## APPOINTMENT OF AGENT TO CONTROL DISPOSITION OF REMAINS

I, _____, of (address) _____,

being of sound mind, willfully and voluntarily make known my desire that, upon my death, the

disposition of my remains shall be controlled by _____, in accordance with

Section 711.002 of the Health and Safety Code and, with respect to that subject only, I hereby appoint such person as my agent (attorney-in-fact). All decisions made by my agent with respect to the disposition of my remains, including cremation, shall be binding.

**SPECIAL DIRECTIONS:**

Set forth below are any special directions limiting the power granted to my agent:

_____

_____

_____

**AGENT:**

Name: _____

Address: _____

Telephone Number: _____

Acceptance of Appointment:

_____

(signature)

_____

(date)

**SUCCESSORS:**

If my agent dies, becomes legally disabled, resigns, or refuses to act, I hereby appoint the following persons (each to act alone and successively, in the order named) to serve as my agent (attorney-in-fact) to control the disposition of my remains as authorized by this document:

**1. First Successor**

Name: _____

Address: _____

Telephone Number: _____

Acceptance of Appointment:

_____

(signature)

_____

**(date)**

**2. Second Successor**

Name: _____

Address: _____

Telephone Number: _____

Acceptance of Appointment:

_____

(signature)

_____ (date)

**DURATION:**

This appointment becomes effective upon my death.

**PRIOR APPOINTMENTS REVOKED:**

I hereby revoke any prior appointment of any person to control the disposition of my remains.

**RELIANCE:**

I hereby agree that any cemetery organization, business operating a crematory or columbarium or both, funeral director or embalmer, or funeral establishment who receives a copy of this document may act under it. Any modification or revocation of this document is not effective as to any such party until that party receives actual notice of the modification or revocation. No such party shall be liable because of reliance on a copy of this document.

**ASSUMPTION:**

THE AGENT, AND EACH SUCCESSOR AGENT, BY ACCEPTING THIS APPOINTMENT, ASSUMES THE OBLIGATIONS PROVIDED IN, AND IS BOUND BY THE PROVISIONS OF, SECTION 711.002 OF THE HEALTH AND SAFETY CODE.

Signed this _____ day of _____ , 20 __ .

(Seal, if any, of notary)

This document was acknowledged before me on _____ by _____.

Date _____

Signature of Notary _____

Printed Name _____

My commission expires: _____.

State of _____

County of _____