

By: Wray

H.B. No. 995

A BILL TO BE ENTITLED

AN ACT

relating to the form and revocation of medical powers of attorney.

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

SECTION 1. The heading to Section 166.155, Health and Safety Code, is amended to read as follows:

Sec. 166.155. REVOCATION; EFFECT OF TERMINATION OF MARRIAGE.

SECTION 2. Section 166.155, Health and Safety Code, is amended by amending Subsection (a) and adding Subsection (a-1) to read as follows:

(a) A medical power of attorney is revoked by:

(1) oral or written notification at any time by the principal to the agent or a licensed or certified health or residential care provider or by any other act evidencing a specific intent to revoke the power, without regard to whether the principal is competent or the principal's mental state; or

(2) execution by the principal of a subsequent medical power of attorney. ~~[, or]~~

(a-1) An agent's authority under a medical power of attorney is revoked if the agent's marriage to [(3) the divorce of] the principal is dissolved, annulled, or declared void [and spouse, if the spouse is the principal's agent,] unless the medical power of attorney provides otherwise.

SECTION 3. Section 166.164, Health and Safety Code, is

1 amended to read as follows:

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

5 MEDICAL POWER OF ATTORNEY DESIGNATION OF HEALTH CARE AGENT.

6 I, _____ (insert your name) appoint:

7 Name:_____

8 Address:_____

9 Phone_____

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

15 LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE
16 AS FOLLOWS:_____

17 _____

18 DESIGNATION OF ALTERNATE AGENT.

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

26 If the person designated as my agent is unable or unwilling to
27 make health care decisions for me, I designate the following

persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent

Name:_____

Address:_____

Phone _____

B. Second Alternate Agent

Name:_____

Address:_____

Phone _____

The original of this document is kept at:

The following individuals or institutions have signed copies:

Name:_____

Address:_____

Name:_____

Address:_____

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

1 authority I have granted my agent continues to exist until the time
2 I become able to make health care decisions for myself.

3 (IF APPLICABLE) This power of attorney ends on the following
4 date: _____

5 PRIOR DESIGNATIONS REVOKED.

6 I revoke any prior medical power of attorney.

7 ~~[ACKNOWLEDGMENT OF]~~ DISCLOSURE STATEMENT.

8 THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL
9 DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE
10 IMPORTANT FACTS:

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

26 Your agent's authority is effective when your doctor
27 certifies that you lack the competence to make health care

1 decisions.

2 Your agent is obligated to follow your instructions when
3 making decisions on your behalf. Unless you state otherwise, your
4 agent has the same authority to make decisions about your health
5 care as you would have if you were able to make health care
6 decisions for yourself.

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

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

25 You should inform the person you appoint that you want the
26 person to be your health care agent. You should discuss this
27 document with your agent and your physician and give each a signed

1 copy. You should indicate on the document itself the people and
2 institutions that you intend to have signed copies. Your agent is
3 not liable for health care decisions made in good faith on your
4 behalf.

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

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

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

21 THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

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

24 (2) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT
25 WITNESSES.

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

27 (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 been provided with a disclosure statement explaining the effect of this document.]~~ I have read and understand the ~~[that]~~ 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)

1 (Signature)
2 _____
3 (Print Name)
4 State of Texas
5 County of _____
6 This instrument was acknowledged before me on _____ (date) by
7 _____ (name of person acknowledging).
8 _____
9 NOTARY PUBLIC, State of Texas
10 Notary's printed name:
11 _____
12 My commission expires:
13 _____
14 OR
15 SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES
16 I sign my name to this medical power of attorney on _____
17 day of _____ (month, year) at
18 _____
19 (City and State)
20 _____
21 (Signature)
22 _____
23 (Print Name)
24 STATEMENT OF FIRST WITNESS.
25 I am not the person appointed as agent by this document. I am
26 not related to the principal by blood or marriage. I would not be
27 entitled to any portion of the principal's estate on the principal's

1 death. I am not the attending physician of the principal or an
2 employee of the attending physician. I have no claim against any
3 portion of the principal's estate on the principal's
4 death. Furthermore, if I am an employee of a health care facility
5 in which the principal is a patient, I am not involved in providing
6 direct patient care to the principal and am not an officer,
7 director, partner, or business office employee of the health care
8 facility or of any parent organization of the health care facility.

9 Signature:_____

10 Print Name:_____ Date:_____

11 Address:_____

12 SIGNATURE OF SECOND WITNESS.

13 Signature:_____

14 Print Name:_____ Date:_____

15 Address:_____

16 SECTION 4. Sections 166.162 and 166.163, Health and Safety
17 Code, are repealed.

18 SECTION 5. Not later than March 1, 2018, the executive
19 commissioner of the Health and Human Services Commission shall
20 adopt all rules necessary to implement this Act.

21 SECTION 6. This Act takes effect September 1, 2017.