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 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 or 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.

SIGN THIS POWER OF ATTORNEY IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

(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 power of attorney is executed, has a claim against any part of your estate after your death.

Sign below to acknowledge your receipt of this disclosure statement prior to your execution of the Medical Power of Attorney, to affirm that YOU HAVE BEEN GIVEN THE OPPORTUNITY (1) TO READ THE ATTACHED STATUTORY POWERS and (2) TO ASK ABOUT THE SCOPE OF ANY POWERS THAT YOU DO NOT FULLY UNDERSTAND.

Signature: _____

Print Name: _____

Date: _____

MEDICAL POWER OF ATTORNEY
DESIGNATION OF HEALTH CARE AGENT

I, _____, appoint:

Name: _____, my _____

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:

1. I, _____, belong to the Catholic Church and I direct that my health care decisions be made in accordance with Catholic teaching.
2. I direct that those making decisions on my behalf be guided by the moral teachings of the Catholic Church. I direct them to consult my priest, my bishop, and/or the National Catholic Bioethics Center to help them in their decision-making, if necessary.
3. On _____, 20__, I executed an Advance Directive, which contains specific directions to be followed if and when I am in a terminal or irreversible condition. When it applies, that Advance Directive shall control any health care decisions to be made on my behalf.
4. Other Limitations: _____

_____

DESIGNATION OF 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 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: _____, my _____

Address: _____

_____

Phone: _____

B. Second Alternate Agent

Name: _____, my _____

Address: _____

_____

Phone: _____

LOCATION OF MEDICAL POWER OF ATTORNEY:

The original of this document is kept at:

_____

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

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.

TERMINATION DATE:

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

_____

PRIOR DESIGNATIONS REVOKED:

I revoke any prior medical power of attorney.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT:

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

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this medical power of attorney on _____, 20___.

Signature: _____

Print Name: _____

Address: _____

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: _____

STATE OF TEXAS)
)
COUNTY OF_____)

Before me, the undersigned authority, personally appeared _____, the Principal, and _____ and _____ as witnesses, proved to me through _____ *(description of identity card or other document)* to be the individuals whose names are subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 20___.

(Personalized Seal)

_____
Notary Public

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