

[This document will be created if you select living will and will vary depending on your choices in regards to life support.]

TEXAS DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

OF

Jane Doe

I. NOTICE AND INSTRUCTIONS

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. Brief definitions are listed below and may aid you in your discussions and advance planning. Initial the treatment choices that you have selected. Provide a copy of your directive to your physician, usual hospital, and family or spokesperson. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

In addition to this advance directive and the Medical Power of Attorney that you have created, Texas law provides for an Out-of-Hospital Do-Not-Resuscitate Order. You may wish to discuss this type of directive with your physician, family, hospital representative, or other advisers.

In addition to this advance directive, Texas law provides for 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.

II. DEFINITIONS

“Artificial nutrition and hydration” means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

“Irreversible condition” means a condition, injury, or illness:

- (1) that may be treated, but is never cured or eliminated;
- (2) that leaves a person unable to care for or make decisions for the person's own self; and
- (3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

“Life-sustaining treatment” means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

“Terminal condition” means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.

III. DIRECTIVE

I, Jane Doe, 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:

[This section will appear if you elect to be kept on life support.]

It is my desire that my life be prolonged as long as reasonable within the limits of generally accepted health care stands.

[This section will appear if you elect to not be kept on life support and will vary depending on your choices.]

If, in the judgment 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.

If, in the judgment 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 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.

If I have a condition stated above, it is my preference to not receive artificially administered nutrition and hydration (food and fluids).

[This section will appear if you write additional health care instructions.]

Additional requests: *This section is reserved for any additional health care instructions you provide.*

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 have not designated a person to make treatment decisions with my physician compatible with my personal values, I understand that a spokesperson will be chosen for me following standards specified in the laws of Texas. If, in the judgment 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 desire to receive treatment for comfort or to alleviate pain except as follows: Sample. 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. I revoke and make null and void any and all other health care directives, declarations, and living wills, previously made by me.

[This section varies depending upon your choices regarding organ donation.]

IV. ANATOMICAL GIFTS

I hereby authorize the making of anatomical gifts of the following parts of my body for the following purposes:

Gift: All organs and parts.
Purpose: Medical purposes only, education, and research.

V. GENERAL STATEMENTS AND PROVISIONS

If any provision hereof is held to be invalid, such invalidity shall not affect the other provisions of this document, and such other provisions shall be given effect without the invalid provision.

It is my intent that this document be legally binding and effective. If the law does not recognize the legal validity of this document, it is my intention that this document be taken as a formal declaration of my intentions concerning all of the above provisions. Copies of this document have the same effect as the original.

All persons or entities that in good faith endeavor to carry out the provisions of this document shall not be liable to me, my estate, or my heirs, for any damages or claims arising because of

their actions or inactions based on this document. My estate shall indemnify and hold them harmless.

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IN WITNESS WHEREOF, I have executed this document on the date below:

Signature of Jane Doe

Dated: _____, 20__

100 Main Street
Austin, Texas 78610

Date of Birth: _____

WITNESS STATEMENT

Each of the undersigned declares that: 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.

Witness 1

Date: _____

Signature: _____

Print Name: _____

Address: _____

Witness 2

Date: _____

Signature: _____

Print Name: _____

Address: _____

[This document is created if you choose to appoint someone to make health care decisions for you. You can appoint an alternate agent if your first choice is unavailable.]

**TEXAS MEDICAL POWER OF ATTORNEY
DESIGNATION OF HEATH CARE AGENT**

OF

Jane Doe

I. 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.

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:

- (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.

II. MEDICAL POWER OF ATTORNEY DESIGNATION OF HEALTH CARE AGENT

I, Jane Doe appoint:

Name: John Doe
Relation: Husband
Address: 100 Main Street
Austin, Texas 78610
Phone: (800) 555-1234
Alt. Phone: (888) 123-5555
Email: jdoe@legalzoomsample.com

as my agent (hereinafter collectively referred to as "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.

[This section varies depending upon your choices regarding organ donation.]

III. DECISION-MAKING AUTHORITY OF MY AGENT REGARDING ANATOMICAL GIFTS

I hereby authorize my agent to make anatomical gifts of the following parts of my body for the following purposes:

Gift: All organs and parts.
Purpose: Medical purposes only, education, and research.

IV. LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

I do not authorize my agent to direct the disposition of my remains.

I do not authorize my agent to consent to an autopsy of my remains.

[The following section appears if you place further limitations on your agent's authority.]

Notwithstanding the foregoing, the authority of my agent is limited as follows: *This section is reserved for any limitations that you place on your agent's authority.*

IV. DESIGNATION OF ALTERNATE AGENT

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:

Name: Ann Doe
Relation: Daughter
Address: 100 Main Street
Austin, Texas 78610
Phone: (800) 555-1234
Alt. Phone: (888) 123-5555
Email: adoe@legalzoomsample.com

V. 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.

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VI. PRIOR DESIGNATIONS REVOKED

I revoke any prior medical powers of attorney.

VII. GENERAL PROVISIONS

If any provision hereof is held to be invalid, such invalidity shall not affect the other provisions of this document, and such other provisions shall be given effect without the invalid provision.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any similar state laws, and exclusively for the purpose of making a determination of my incapacitation or inability to direct my own health care decisions and obtaining a physician affidavit of such, I authorize any health care provider to disclose to the person named herein as my health care agent or alternate health care agent, as applicable, any pertinent individually identifiable health information sufficient to determine whether I am by reason of illness or mental or physical disability incapacitated or incapable of directing my own health care decisions. In exercising such authority, my health care agent shall constitute my "personal representative" as defined by HIPAA.

Upon the determination of my incapacitation or inability to direct my own health care decisions, I intend for the person named herein as my health care agent or alternate health care agent, as applicable, to be treated as my "personal representative" under HIPAA and any similar state law, and as such to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records.

It is my intent that this document be legally binding and effective. If the law does not recognize the legal validity of this document, it is my intention that this document be taken as a formal declaration of my intentions concerning all of the above provisions. Copies of this document have the same effect as the original.

All persons or entities that in good faith endeavor to carry out the provisions of this document shall not be liable to me, my estate, or my heirs, for any damages or claims arising because of their actions or inactions based on this document. My estate shall indemnify and hold them harmless.

VII. 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.

I sign my name to this medical power of attorney on ____ day of _____, 20____ at

(City and State)

Signature of Jane Doe

(Print Name)

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VIII. WITNESS STATEMENT

Each of the undersigned declares that: 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.

Witness 1

Date: _____

Signature: _____

Print Name: _____

Address: _____

Witness 2

Date: _____

Signature: _____

Print Name: _____

Address: _____

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