Medical Directives LLC

5307 Allum Rd., Unit B
Houston TX 77045
MedicalDirectives.net
T/F: 866 -300-7388

Thank you for downloading the PDF-fillable form for your Medical Directive, Advance Medical Directive, or Medical Power of Attorney. The process is very straightforward:

1. Choose the subscription type you want and pay online. We use paypal for all credit card processing and NEVER store your Credit Card Information.
2. Download the form to your computer.
3. Fill it out on your computer and print it.
4. Take the filled-form to your favorite notary (or your witnesses) and have it notarized or witnessed.
5. Fax your paperwork to 866-300-7388. If you want to email it instead, please SCAN all to PDF utilizing 200 DPI scan settings, making 1 PDF file, and email to forms@medicaldirectives.net
6. Your Retrieval Card is emailed out to you within 24 hours of receiving your medical directive. If you lose it or need another one, you can generate one easily on our web portal .

Here is the form for the state you selected. Please do not fax back any instruction sheets. We do not require a coversheet when you fax.

DISCLOSURE STATEMENT

PART I: Medical Power of Attorney

Disclosure Statement for Medical Power of Attorney

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

DISCLOSURE STATEMENT (CONTINUED)

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:

(1) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR
(2) YOU SIGN IT 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 your 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.

IF YOU PLAN TO DESIGNATE AN AGENT IN PART I, YOU MUST READ AND UNDERSTAND THE DISCLOSURE STATEMENT AND SIGN AND DATE HERE BEFORE EXECUTING YOUR ADVANCE DIRECTIVE

Acknowledgement of Disclosure Statement

I am signing this acknowledgement that I have received, read, and understand the above disclosure statement prior to executing the medical power of attorney in this document.

_____ _____
Signature Date

Printed Name

TEXAS MEDICAL POWER OF ATTORNEY

DESIGNATION OF HEALTH CARE AGENT.

PRINT YOUR NAME

PRINT THE NAME, ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR AGENT

I, _____, appoint:
(name)

_____
(name of agent)

_____
(address)

_____
(work telephone number) (home telephone number)

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.

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR AGENT'S AUTHORITY

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

_____

_____

_____

_____

_____

_____

_____

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:

PRINT THE NAME, ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT

A. First Alternate Agent

_____
(name of first alternate agent)

_____
(home address)

_____
(work telephone number) (home telephone number)

PRINT THE NAME, ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT

B. Second Alternate Agent

_____
(name of second alternate agent)

_____
(home address)

_____
(work telephone number) (home telephone number)

PRINT LOCATION OF ORIGINAL

The original of this document is kept at: _____

_____

_____

PRINT THE NAMES AND ADDRESSES OF PEOPLE OR INSTITUTIONS YOU PLAN TO GIVE COPIES OF YOUR ADVANCE DIRECTIVE

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

EXPIRATION DATE (IF ANY)

(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 understood that information contained in the disclosure statement, and signed the acknowledgment on page 2 of this form prior to execution of this advance directive.

INSTRUCTIONS FOR DIRECTIVE

PART II: Directive to Physicians and Family or Surrogates

Instructions for completing this document:

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 this 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 (Part I) 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

PRINT YOUR NAME

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:

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES ABOUT TREATMENT IN THE EVENT OF A TERMINAL CONDITION

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:

INITIAL ONLY ONE

_____ 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)

INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES IN THE EVENT OF AN IRREVERSIBLE CONDITION

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:

INITIAL ONLY ONE

_____ 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)

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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. If you wish, you can also specify that you would like to make an organ donation. Be sure to include any restrictions, such as who may become a donee, what organs you authorize to be donated, etc.)*

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.

DESIGNATION OF A SPOKESPERSON

IF YOU HAVE COMPLETED A MEDICAL POWER OF ATTORNEY (PART I) DO NOT COMPLETE THIS SECTION

If I do not have a Medical Power of Attorney and/or have not filled out Part I, 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. _____
(name of person)

2. _____
(name of second person)

(IF A MEDICAL POWER OF ATTORNEY SUCH AS PART I, HAS BEEN EXECUTED, THEN AN AGENT HAS BEEN NAMED AND YOU SHOULD NOT LIST ADDITIONAL NAMES IN THIS PART.)

If the above persons are not available, or if I have not designated a spokesperson, I understand that the 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 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.

PART III: Explanation of Terms

EXPLANATION OF IMPORTANT TERMS

"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.

IF YOU DO NOT UNDERSTAND THESE TERMS, OR ANY OTHER PART OF THIS ADVANCE DIRECTIVE, YOU SHOULD ASK A LAWYER TO EXPLAIN THEM TO YOU

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.

PART IV: EXECUTION

This Advance Directive will not be valid unless it is EITHER:

(A) Signed by two (2) adult witnesses who are present when you sign or acknowledge your signature.

Two competent adult witnesses must sign as witnesses, acknowledging the signature of the declarant.

IF YOU DECIDE TO HAVE YOUR ADVANCE DIRECTIVE WITNESSED, USE ALTERNATIVE NO. 1, BELOW (P. 18)

Witness 1 may not be a person designated to make a treatment decision for you and may not be related to you by blood or marriage. This witness may not be entitled to any part of your estate and may not have a claim against your estate. This witness may not be your attending physician or an employee of your attending physician. If this witness is an employee of a health care facility in which you are being cared for, this witness may not be involved in providing direct patient care to you. This witness may not be an officer, director, partner, or business office employee of a health care facility in which you are being cared for or of any parent organization of the health care facility.

Any competent adult can sign as Witness 2.

(If you decide to have your advance directive witnessed, use alternative No. 1, below.)

IF YOU DECIDE TO HAVE YOUR ADVANCE DIRECTIVE NOTARIZED, USE ALTERNATIVE NO. 2, BELOW (P. 19)

OR

(B) Witnessed by a notary.

(If you decide to have your advance directive notarized, use alternative No. 2, below.)

NOTE: IF YOU HAVE FILLED OUT PART I, YOU MUST SIGN THE ACKNOWLEDGMENT ON PAGE 3 STATING THAT YOU HAVE READ AND UNDERSTAND THE DISCLOSURE STATEMENT ON PAGES 1-3 BEFORE YOU EXECUTE THIS DOCUMENT.

SIGN AND DATE YOUR ADVANCE DIRECTIVE

PRINT YOUR NAME

AT LEAST ONE WITNESS MUST MEET THESE REQUIREMENTS AND SIGN AS WITNESS 1

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE

ANY COMPETENT ADULT CAN SIGN AS WITNESS 2

Alternative No. 1: Sign Before Witnesses

_____ _____
(signature) (date)

_____
(printed name)

WITNESSES

Witness No. 1

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.

_____ _____
(signature of Witness 1) (date)

_____
(printed name of Witness 1)

Witness No. 2

_____ _____
(signature of Witness 2) (date)

_____
(printed name of Witness 2)

Alternative No. 2: Sign Before a Notary Public

SIGN AND DATE YOUR ADVANCE DIRECTIVE

_____ _____
(signature) (date)

PRINT YOUR NAME

_____
(printed name)

A NOTARY PUBLIC SHOULD COMPLETE THIS SECTION OF YOUR DOCUMENT

State of Texas,)
) ss.
County of _____)

On this _____ day of _____ 20_____, before me,

_____, a notary public in

_____ County, personally

came_____,
personally known to be the identical person whose name is affixed above, and I declare that he or she appears in sound mind and not under duress or undue influence, that he or she acknowledges the execution of the same to be his or her voluntary act and deed.

Witness my hand and notarial seal at _____
in such county the day and year last above written.

SEAL

_____
signature of notary public

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

TEXAS ORGAN DONATION FORM – PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under Texas law.

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to Texas law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

_____

For (initial one):
_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____
_____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____
_____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

Texas Medical Power of Attorney Form

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 my physician certifies this fact in writing.

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

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:

First Alternate Agent
Name: _____
Address: _____
_____
Phone: _____

Second Alternate Agent
Name: _____
Address: _____
_____
Phone: _____
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.

(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
_____day of _____month _____year
at _____. (City and State)
_____ (Signature)
_____ (Print Name)

Statement of Witness
I am not the person appointed an 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: _____
Address: _____
_____
Date: _____
Signature: _____
Print Name: _____
Address: _____
_____
Date: _____