MEDICAL DURABLE POWER OF ATTORNEY

I. APPOINTMENT OF ATTORNEY-IN-FACT

I, _____, my date of birth being _____, hereby appoint _____, whose date of birth is _____, as my attorney-in-fact and agent to make any and all health care decisions for me as described in this document, except to the extent I state otherwise herein.

II. ALTERNATE

If the above-named attorney in fact is unable or unwilling to act as my attorney-in-fact to make health care decisions for me, then I appoint _____, whose date of birth is _____, as my first alternate attorney-in-fact to make such health care decisions for me.

III. EFFECTIVE DATE AND DURABILITY

This medical durable power of attorney is effective when a physician certifies I am incapacitated or unable to communicate a health care decision. I understand 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.

IV. POWERS

I grant my attorney-in-fact the following authority to:

Cross out any power you do not want your agent to have)

A. Consent to, prohibit or withdraw any type of health care, medical care, treatment or procedure, even if my death may result;

B. Make decisions regarding organ donation, autopsy and the disposition of my body;

C. Make all necessary arrangements for health care services on my behalf, and to hire and discharge medical personnel responsible for my care;

D. Request, receive and review any information, oral or written, regarding my personal affairs or physical or mental health; and

E. Take any other action necessary to do what I authorize in this instrument, including, but not limited to, granting any release from liability required by any health care provider, and taking any legal action to enforce this medical durable power of attorney.

V. FINANCIAL LIABILITY AND COMPENSATION

My attorney-in-fact will incur no personal financial liability for acting in accordance with my medical durable power of attorney. My attorney-in-fact shall not be entitled to compensation for services performed under this medical durable power of attorney.

VI. RELIANCE ON ATTORNEY-IN-FACT

I and my estate hold my attorney-in-fact and my caregivers harmless against any claim for following this medical durable power of attorney.

VII. VALIDITY

This document is intended to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be as valid as the original.

THIS IS A DURABLE POWER OF ATTORNEY, AND THE AUTHORITY OF MY ATTORNEY-IN-FACT SHALL NOT TERMINATE IF I BECOME DISABLED OR INCAPACITATED.

VIII. REVOCATION OF PREVIOUS INSTRUMENTS

I revoke any prior medical power of attorney.

IX. ACKNOWLEDGEMENT OF DISCLOSURE

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.

X. EXECUTION

IN WITNESS HEREOF, I execute this instrument.

Signature of Principal: _____ Dated: _____

Printed Name of Principal: _____

ACKNOWLEDGEMENT

Executed in lieu of two witnesses per §166.154(b) of the Texas Health and Safety Code.

On this day, before me, the undersigned authority, personally appeared _____, the person whose name is affixed to the foregoing instrument, and he/she acknowledge to me he/she executed same for the purposes therein expressed. WITNESS my hand and official seal on this _____ day of _____, 20_____.

_____
Notary Public – State of Texas

DISCLOSURES REGARDING 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.

In lieu of two witnesses signing your medical power of attorney, Section 166.154(b) of the Texas Health and Safety Code allows you to appear before a notary public and have your signature acknowledged.

I acknowledge that I have received and read the above Disclosures Regarding Medical Power of Attorney. I understand its contents and have received this disclosure before executing my Medical Power of Attorney.

Dated: _____ Signature: _____

Printed Name: _____

HIPAA RELEASE

I,_____, my date of birth being _____, and the last four digits of my Social Security number being _____, intend for any agent named in this release to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 C.F.R. 160-164.

I authorize the disclosure of any information governed by HIPAA to be provided to the following:

Name: _____ DOB: _____

Accordingly, I hereby authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to any agent who is named herein and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

This authority given to any named agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to any named agent may be subject to redisclosure by a named agent and may no longer be protected by HIPAA. The authority given to any named agent herein has no expiration date and shall expire only in the event that I revoke this HIPAA Release in writing and deliver it to my health-care provider. There are no exceptions to my right to revoke this HIPAA Release.

Dated: _____

Signature: _____

Printed Name: _____

On this day, before me, the undersigned appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, and he/she acknowledge to me he/she executed same for the purposes therein express. WITNESS my hand and official seal on this _____ day of _____, 2012.

_____

Notary Public – State of Texas