

By: Rodríguez

S.B. No. 310

A BILL TO BE ENTITLED

1 AN ACT

2 relating to the authority granted under and form of a medical power
3 of attorney.

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

5 SECTION 1. Subchapter D, Chapter 166, Health and Safety
6 Code, is amended by adding Section 166.1525 to read as follows:

7 Sec. 166.1525. DESIGNATION OF JOINT AGENCY. (a) A medical
8 power of attorney may designate two or more agents to act as joint
9 agents and may provide the method of joint agency.

10 (b) If a medical power of attorney designates two or more
11 agents to act as joint agents but does not provide a method of joint
12 agency, an agent is authorized to act independently as the sole
13 agent in the priority order in which the medical power of attorney
14 lists the agents.

15 (c) If a medical power of attorney designates two or more
16 agents to act as joint agents and provides a method of joint agency
17 and the agents are unable to agree on a health care decision, an
18 agent may act independently as the sole agent in the priority order
19 in which the medical power of attorney lists the agents. This
20 subsection does not affect the authority of the agents to act as
21 joint agents in accordance with the power of attorney for a health
22 care decision on which all agents agree.

23 SECTION 2. Section 166.160(d), Health and Safety Code, is
24 amended to read as follows:

1 (d) An attending physician, health or residential care
2 provider, or person acting as an agent for or under the physician's
3 or provider's control has not engaged in unprofessional conduct
4 for:

5 (1) failure to act as required by the directive of an
6 agent or a medical power of attorney if the physician, provider, or
7 person was not provided with a copy of the medical power of attorney
8 or had no knowledge of a directive; ~~[or]~~

9 (2) acting as required by an agent's directive if the
10 medical power of attorney has expired or been revoked but the
11 physician, provider, or person does not have knowledge of the
12 expiration or revocation; or

13 (3) acting as required by an agent's directive if the
14 medical power of attorney was not validly executed, provided the
15 physician, provider, or person does not have actual knowledge of
16 the medical power of attorney's invalid execution.

17 SECTION 3. Subchapter D, Chapter 166, Health and Safety
18 Code, is amended by adding Section 166.163 to read as follows:

19 Sec. 166.163. PERMISSIBLE FORMS OF MEDICAL POWER OF
20 ATTORNEY. A medical power of attorney may be in a form:

21 (1) described by Section 166.164;

22 (2) authorized under Section 166.005; or

23 (3) that:

24 (A) meets the requirements of this subchapter,
25 including execution in accordance with Section 166.154;

26 (B) is in writing; and

27 (C) contains:

5 SECTION 4. Section 166.164, Health and Safety Code, is
6 amended to read as follows:

7 Sec. 166.164. FORM OF MEDICAL POWER OF ATTORNEY. A [The]
8 medical power of attorney may [~~must~~] be in [~~substantially~~] the
9 following form:

10 MEDICAL POWER OF ATTORNEY DESIGNATION OF HEALTH CARE AGENT.

11 I, _____ (insert your name) appoint:

12 Name: _____

13 Address: _____

14 Phone: _____

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

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

23 DESIGNATION OF ALTERNATE AGENT.

24 (You are not required to designate an alternate agent but you

25 may do so. An alternate agent may make the same health care
26 decisions as the designated agent if the designated agent is unable
27 or unwilling to act as your agent. If the agent designated is your

S.B. No. 310

1 spouse, the designation is automatically revoked by law if your
2 marriage is dissolved, annulled, or declared void unless this
3 document provides otherwise.)

4 If the person designated as my agent is unable or unwilling to
5 make health care decisions for me, I designate the following
6 persons to serve as my agent to make health care decisions for me as
7 authorized by this document, who serve in the following order:

8 A. First Alternate Agent

9 Name: _____

10 Address: _____

11 Phone: _____

12 B. Second Alternate Agent

13 Name: _____

14 Address: _____

15 Phone: _____

16 The original of this document is kept at:

17 _____

18 _____

19 _____

20 The following individuals or institutions have signed
21 copies:

22 Name: _____

23 Address: _____

24 _____

25 Name: _____

26 Address: _____

27 _____

1 DURATION.

2 I understand that this power of attorney exists indefinitely
3 from the date I execute this document unless I establish a shorter
4 time or revoke the power of attorney. If I am unable to make health
5 care decisions for myself when this power of attorney expires, the
6 authority I have granted my agent continues to exist until the time
7 I become able to make health care decisions for myself.

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

10 PRIOR DESIGNATIONS REVOKED.

11 I revoke any prior medical power of attorney.

12 DISCLOSURE STATEMENT.

13 THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL
14 DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE
15 IMPORTANT FACTS:

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

1 psychosurgery, or abortion. A physician must comply with your
2 agent's instructions or allow you to be transferred to another
3 physician.

4 Your agent's authority is effective when your doctor
5 certifies that you lack the competence to make health care
6 decisions.

7 Your agent is obligated to follow your instructions when
8 making decisions on your behalf. Unless you state otherwise, your
9 agent has the same authority to make decisions about your health
10 care as you would have if you were able to make health care
11 decisions for yourself.

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

21 The person you appoint as agent should be someone you know and
22 trust. The person must be 18 years of age or older or a person under
23 18 years of age who has had the disabilities of minority removed.
24 If you appoint your health or residential care provider (e.g., your
25 physician or an employee of a home health agency, hospital, nursing
26 facility, or residential care facility, other than a relative),
27 that person has to choose between acting as your agent or as your

1 health or residential care provider; the law does not allow a person
2 to serve as both at the same time.

3 You should inform the person you appoint that you want the
4 person to be your health care agent. You should discuss this
5 document with your agent and your physician and give each a signed
6 copy. You should indicate on the document itself the people and
7 institutions that you intend to have signed copies. Your agent is
8 not liable for health care decisions made in good faith on your
9 behalf.

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

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

22 You may wish to designate an alternate agent in the event that
23 your agent is unwilling, unable, or ineligible to act as your agent.
24 If you designate an alternate agent, the alternate agent has the
25 same authority as the agent to make health care decisions for you.

26 You may wish to designate two or more agents to act as joint
27 agents and may provide the method of joint agency. If you do not

S.B. No. 310

1 provide a method of joint agency, an agent is authorized to act
2 independently as the sole agent in the priority order in which you
3 list the agents, and third parties may rely on the decisions of the
4 agent.

5 THIS POWER OF ATTORNEY IS NOT VALID UNLESS:

6 (1) YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED
7 BEFORE A NOTARY PUBLIC; OR
8 (2) YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT
9 WITNESSES.

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

11 (1) the person you have designated as your agent;
12 (2) a person related to you by blood or marriage;
13 (3) a person entitled to any part of your estate after
14 your death under a will or codicil executed by you or by operation
15 of law;
16 (4) your attending physician;
17 (5) an employee of your attending physician;
18 (6) an employee of a health care facility in which you
19 are a patient if the employee is providing direct patient care to
20 you or is an officer, director, partner, or business office
21 employee of the health care facility or of any parent organization
22 of the health care facility; or
23 (7) a person who, at the time this medical power of
24 attorney is executed, has a claim against any part of your estate
25 after your death.

26 By signing below, I acknowledge that I have read and
27 understand the information contained in the above disclosure

S.B. No. 310

1 statement.

2 (YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN
3 IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR
4 YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)

5 SIGNATURE ACKNOWLEDGED BEFORE NOTARY

6 I sign my name to this medical power of attorney on _____
7 day of _____ (month, year) at

8 _____

9 (City and State)

10 _____

11 (Signature)

12 _____

13 (Print Name)

14 State of Texas

15 County of _____

16 This instrument was acknowledged before me on _____ (date) by
17 _____ (name of person acknowledging).

18 _____

19 NOTARY PUBLIC, State of Texas

20 Notary's printed name:

21 _____

22 My commission expires:

23 _____

24 OR

25 SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

26 I sign my name to this medical power of attorney on _____

27 day of _____ (month, year) at

S.B. No. 310

1 _____

2 (City and State)

3 _____

4 (Signature)

5 _____

6 (Print Name)

7 STATEMENT OF FIRST WITNESS.

8 I am not the person appointed as agent by this document. I am
9 not related to the principal by blood or marriage. I would not be
10 entitled to any portion of the principal's estate on the principal's
11 death. I am not the attending physician of the principal or an
12 employee of the attending physician. I have no claim against any
13 portion of the principal's estate on the principal's
14 death. Furthermore, if I am an employee of a health care facility
15 in which the principal is a patient, I am not involved in providing
16 direct patient care to the principal and am not an officer,
17 director, partner, or business office employee of the health care
18 facility or of any parent organization of the health care facility.

19 Signature: _____

20 Print Name: _____ Date: _____

21 Address: _____

22 SIGNATURE OF SECOND WITNESS.

23 Signature: _____

24 Print Name: _____ Date: _____

25 Address: _____

26 SECTION 5. Not later than December 1, 2019, the executive
27 commissioner of the Health and Human Services Commission shall

S.B. No. 310

1 adopt the rules necessary to implement the changes in law made by
2 this Act.

3 SECTION 6. The changes in law made by this Act apply only to
4 a medical power of attorney executed on or after the effective date
5 of this Act. A medical power of attorney executed before the
6 effective date of this Act is governed by the law in effect
7 immediately before the effective date of this Act, and the former
8 law is continued in effect for that purpose.

9 SECTION 7. This Act takes effect September 1, 2019.