Comments and Execution Instructions – Medical Power of Attorney and HIPAA Authorization

In this document the principal appoints an agent to act on the principal's behalf in making medial treatment decisions, ***only*** in the event the principal is unable to do this for himself or herself. **Be sure the person appointed is familiar with what the principal would want.**

The attached HIPAA authorization allows the persons named in the Medical Power of Attorney to have access to the principal's medical records, in case the Medical Power is not enough to allow for that under the policies of the specific medical provider.

The principal should provide a copy of this document to his or her health care provider to be kept in the chart, and take a copy of this if he or she is ever admitted to a hospital.

This is a Texas document. It may not be accepted in other states or countries. However, if you need it and this is all you have, you ought to at least present it wherever you are.

Only one agent at a time may be named. If the principal wants to name any alternate agents, those persons' name, address and phone may be entered in the space provided in Article II.A of this document. Also put the alternate agent into the list (on page 2) of persons who have a copy of this document. Generally, if a lawyer is involved in the preparation of the document the attorney would also retain a copy of the document and would be included in that list.

Note that the document indicates that the original of the power will be kept with the first agent, since that is the person who will need to have it if the power is ever required to be presented. **Note also** that the limitations section of Article I of the power itself presupposes that the principal has executed a directive to physicians ("living will"). If that is not the case, that language should be deleted.

To execute this document: You will need two witnesses who are generally unrelated to the principal and not providing the principal's health care.

Disclosure statement. At the beginning of this document is a two page disclosure statement that describes the document. The principal should first read and then sign that statement.

Medical Power of Attorney. The principal should then sign and date the Power on page 2 where indicated in the presence of the two witnesses. Each witness should read the statement at the end of the Power to verify the accuracy of the statement as applicable to each of them and, if accurate at to each of them, each witness should sign his or her name where indicated at the end of the Power, print his or her name, and enter his or her home address.

INFORMATION CONCERNING
THE MEDICAL POWER OF ATTORNEY
OF

_____

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.

I acknowledge receipt of this disclosure statement prior to execution of the Medical Power of Attorney that follows, and I affirm that I have read and understand the information contained in this disclosure statement.

Dated this _____ day of _____, 20____.

_____

Print name: _____

MEDICAL POWER OF ATTORNEY OF

_____

I.
DESIGNATION OF HEALTH CARE AGENT.

I, _____, 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 this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS: I have previously executed a Directive to Physicians and Family or Surrogates ("Advance Directive"), setting forth my directions regarding the withholding of life-sustaining procedures under the circumstances described therein. Unless and until that Advance Directive is revoked and I have not executed a subsequent Advance Directive or similar document, my agent shall have no authority to make any decision in contravention of my requests set forth in that Advance Directive or similar document, unless my physician believes such Advance Directive or similar document no longer reflects my wishes.

II.
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:
Address:
Phone:

The original of this document is kept with _____(name), at _____ (address).

The following individuals or institutions have copies of this instrument:

Name:
Address:

III.
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.

IV.
PRIOR DESIGNATIONS REVOKED.

I revoke any prior medical power of attorney.

V.
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 the ____ day of _____, 20____ at _____, Texas.

_____
Print name: _____

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: _____, (year)

Address:_____

SIGNATURE OF SECOND WITNESS.

Signature:_____

Print Name:_____ Date: _____, (year)

Address:_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION PURSUANT TO 45 CFR § 164.508 AS REQUIRED UNDER HIPAA

I Statement of Intent

I understand that Congress has passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that, in part, limits a health-care provider's ability to disclose medical information related to my care.

I am signing this authorization in order to ensure that my health-care providers, of whatever kind, readily provide and discuss medical information related to me that might otherwise be protected with the person or persons designated in this authorization.

I intend that this authorization shall be effective from the moment it is signed, so that once this authorization is executed any health-care provider shall be permitted to lawfully disclose my "protected health information" pursuant to and in compliance with this authorization.

II Authorization

Pursuant to 45 CFR § 164.502(a)(1)(iv), any covered entity (being a medical provider as defined by HIPAA) is permitted to disclose protected health information related to me pursuant to and in compliance with this authorization, prepared by me to be an authorization described in 45 CFR § 164.508.

I_____, hereby authorize any "covered entity" providing health-care or medical services to me, including without limitation the following:

> all covered entities as defined in HIPAA, including but not limited to any doctor (whether medical, osteopathic, podiatric or chiropractic), psychiatrist, psychologist, dentist, therapist, nurse, hospital, clinic, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, intending this description to be construed to be inclusive of any such provider or similar person or entity, whether or not specifically described above;

to disclose my protected health information, including without limitation the following:

> all health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare;

to the following named person(s), referred to in this Authorization as "authorized person(s)," who shall serve in the following order:

A. First Authorized Person

Name: _____
Address: _____
Phone: _____

B. Second Authorized Person

Name:
Address:
Phone:

III Construe as a General Authorization.

I direct that the disclosure permitted under this Authorization shall include the ability of my authorized persons to ask questions and discuss my health information, whether or not such information is protected health information, with the person or entity who has possession of that health information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention and direction that this Authorization shall be construed to grant full authority to all and any covered persons or entities to disclose to and discuss with the authorized person(s) named in this Authorization all or any of my health information, including all or any of my protected health information.

IV Termination and Revocation.

This Authorization shall terminate on the first to occur of: (1) the second anniversary of the date of my death or (2) upon my written revocation of this Authorization, signed and dated by me, actually received by the covered entity. Proof of receipt of my written revocation of this Authorization may be by certified mail, registered mail, facsimile, or any other manner of transmission that includes a receipt evidencing actual receipt by the covered entity. Revocation shall be effective upon the actual receipt by the covered entity of the notice of revocation, signed and dated by me, except to the extent that the covered entity has taken action in reliance on this Authorization.

V Third Party Reliance.

A photocopy or facsimile of this signed original Authorization shall be accepted as though it were an original document. I agree that any third party who receives a copy of this signed authorization may act under it.

VI Re-disclosure.

By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by an authorized person appointed under this Authorization, and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require my authorized person(s) to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this authorization.

VII Instructions to my authorized persons.

My authorized persons shall have the right to bring a legal action in any applicable form against any covered entity that refuses to recognize and accept this Authorization for the purposes that I have expressed. Additionally, my authorized persons are authorized to sign any documents that the authorized persons deem appropriate to obtain the protected health information.

VIII My waiver and release.

I hereby release any covered entity that acts in reliance on this Authorization from any liability that may accrue from releasing my protected health information and for any actions taken by my authorized persons.

Signed this ____ day of _____, (year).

_____

Print name: _____