Advance Directives Information

These important planning documents include the Medical Power of Attorney, Directive to Physicians or Living Will, and HIPAA Authorization.

What happens if you cannot tell us what you want us to do, or you become so sick you cannot make important decisions? Your doctor will consult with your family and try to determine what your wishes would be.

How can you be sure your family and your doctor will know what to do? Texas law provides Advance Directives for you to do this:

Medical Power of Attorney. With this form you can designate an agent who will make decisions about your treatment in the event your illness becomes so serious that your doctor determines that you are no longer capable of making decisions. If you decide to use this form, you should choose someone you trust and be sure the person understands your feelings about medical treatment.

Directive to Physicians or a **Living Will.** With this you can tell your doctor and family what treatments you want or do not want in the event your illness reaches the point that you are considered terminally ill. It is especially important to consult with your doctor, as your doctor can best advise you about the kinds of treatment likely to be proposed to you.

HIPAA Authorization. If you wish to authorize a relative or appointed agent to access your medical record, you will need to complete this. Completing this will give your designee access to your record at a particular health care facility.

Other Documents

Out of Hospital Do-Not-Resuscitate Order. Filed by you with your physician, this is *immediately* effective and communicates to all agencies that you are **not** to be resuscitated should your heart stop or you lose your airway, but kept comfortable.*It comes into effect upon signing it, and should be kept with you or posted clearly at your place of residence.

Inpatient Oral Directive to Physician. Texas Law requires a new request be made to the attending physician upon admission to a hospital if a person wishes to **not** be resuscitated during a hospital stay. This will be documented and witnessed for the attending physician to sign. It will indicate that if your heart stops or you stop breathing *during your stay*, you wish **not** be resuscitated, but kept comfortable. This also may be referred to as “DNR” or “AND” (Allow Natural Death).

What to do with my forms?

Upon completing an advance directive, you should inform your physician and agent/family and present a copy to them and the hospital for your medical record. You have the right to revoke or change your advance directives at any time. Simply complete a new form, sign appropriately, and give a copy to your physician and hospital. This will revoke all previous advance directives of its kind.

If you have completed a valid directive in another state, Texas Law requires it be honored. However, it is best to sign a new form to avoid any doubt about the validity of the document from out of state.

All these forms are available at Hill Country Memorial Hospital or you can access forms at the Texas Health and Human Services site: https://hhs.texas.gov/laws-regulations/forms/advance-directives.

If you would like help formulating Advance Directives during your Hospital stay, please notify one of your care providers, and we will ensure that you are provided careful guidance. You can go online to learn more or download forms at https://hillcountrymemorial.org/page/advanced-care-planning/. You may also contact Medical Records at 830.997.1281 or Pastoral Care at 830.997.6125 to talk with someone directly.

Updated: 3/23/2020

Definitions:

"Artificially administered 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 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 artificially administered nutrition and hydration. 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.

“Identifiable health information” includes but is not limited to the following:
All healthcare information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers and insurers, whether past, present or future and any other medical information which is in any way related to my healthcare.

“Protected Health Information” (PHI) as sometimes used in HIPAA, includes but is not limited to the following: Doctors (including but not limited to physicians, podiatrists, chiropractors, or osteopaths), psychiatrists, psychologists, dentists, therapists, nurses, hospitals, clinics, pharmacies, laboratories, ambulance services, assisted living facilities, residential care facilities, bed and board facilities, nursing homes, medical insurance companies or any other medical providers or affiliates. In the HIPAA authorization, the term also includes the term covered entity.

MEDICAL POWER OF ATTORNEY
DESIGNATION OF HEALTH CARE AGENT

Advance Directives Act (see §166.164, Health and Safety Code)

I,_____ (insert your name) appoint:
Name: _____ Phone: _____
Address: _____
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:

_____
_____
_____
_____

DESIGNATION OF AN 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 annulled, or declared void unless this document provides otherwise.)
If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s) 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 the document is kept at

_____

The following individuals or institutions have signed copies:
Name: _____
Address: _____

Name: _____
Address: _____

DURATION
I understand that this power 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.

DISCLOSURE STATEMENT

THIS MEDICAL POWER OF ATTORNEY 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 unable to make the decisions for 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 is effective 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 if you were able to make health care decisions for yourself.

It is important that you discuss this document with your physician or other health care provider before you sign the document to ensure 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 facility, or residential care facility, 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 allow a person to serve as 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 that you intend to have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Once you have signed this document, you have the right to make health care decisions for yourself as long as you are able to make those decisions, 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 in this document, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void.

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

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. If you designate an alternate agent, the alternate agent has the same authority as the agent 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 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 medical power of attorney is executed, has a claim against any part of your estate after your death.

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

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

I sign my name to this medical power of attorney on _____ day of _____ (month, year) at _____
(City and State)

_____
(Signature)

_____
(Print Name)
State of Texas
County of _____

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

_____
NOTARY PUBLIC, State of Texas

Notary Printed Name:

_____

My Commission expires:

_____

OR

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: _____

Address: _____

SIGNATURE OF SECOND WITNESS

Signature:_____

Print Name: _____

Date: _____

Address: _____

DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES

Advance Directives Act (see §166.033, Health and Safety Code)

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.

DIRECTIVE

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 or treatment 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:

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; 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.)

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 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; 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.)

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 artificially administered nutrition and hydration, intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

_____
_____
_____
_____

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 do **not** have a Medical Power of Attorney, and I am unable to make my wishes known, I designate the following person(s) to make health care or treatment decisions with my physician compatible with my personal values: (name and phone)

1. _____
2. _____

(If a Medical Power of Attorney has been executed, then an agent already has been named and you should not list additional names in this document.)

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

Signed: _____
Print Name: _____
Date: _____
City, County, State of Residence:_____

Two competent adult witnesses must sign below, acknowledging the signature of the declarant. The witness designated as **Witness 1** may not be a person designated to make a health care or treatment decision for the patient and may not be related to the patient by blood or marriage. This witness may not be entitled to any part of the estate and may not have a claim against the estate of the patient. This witness may not be the attending physician or an employee of the attending physician. If this witness is an employee of a health care facility in which the patient is being cared for, this witness may not be involved in providing direct patient care to the patient. This witness may not be an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or of any parent organization of the health care facility.

Witness 1 _____ Witness 2 _____

HIPAA AUTHORIZATION FORM

STATEMENT OF INTENT:It is my understanding that Congress passed a law entitled “Health Insurance Portability and Accountability Act of 1996” also known as HIPAA. There are federal regulations that interpret and implement that law. HIPAA limits disclosure of my individually identifiable health information to certain family members and friends, regardless of my state of health. I am signing this authorization so that my healthcare provider can disclose my healthcare information to the persons listed and openly discuss that information with them.

AUTHORIZATION: I,_____, hereby authorize my physicians, nurses, hospitals and other healthcare providers to fully disclose my individually identifiable health information to any or all of the following authorized persons designated as my personal representatives.

NAME:_____
ADDRESS:_____
PHONE:_____

NAME:_____
ADDRESS:_____
PHONE:_____

NAME:_____
ADDRESS:_____
PHONE:_____

Patient’s Signature:_____
Date:_____

Two Witnesses: Witness #1 _____Witness #2 _____

OR

Notary Public

This document was acknowledged before me on by
_____(name)

Signed this day of _____, 20_, at Gillespie County, Texas.

Signature of Notary Public State of Texas County of Gillespie
_____

Printed Name: _____ DOB:_____

AUTHORITY TO DISCUSS AND ANSWER QUESTIONS:
My healthcare providers are expressly authorized to answer questions posed by the personal representatives listed above and openly discuss with them my condition, treatment, test results, prognosis, and everything pertinent to my healthcare, even if I am fully competent to ask questions and discuss this matter at the time. This document constitutes a full authorization to disclose any individually identifiable health information to the personal representatives named in this authorization.

WAIVER AND RELEASE:
I hereby release any healthcare provider that acts in reliance on this authorization from any liability that may accrue from releasing my individually identifiable health information and for any actions taken by my personal representatives.

TERMINATION:
This authorization is effective as of the date shown as the date of its signing and shall not be affected by my subsequent disability or incapacity. This authorization shall terminate on the first to occur of

1. two years following my death, or

2. upon my written revocation actually received by the healthcare provider. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile or any other receipt evidencing actual receipt by the healthcare provider.

REDISCLOSURE:
By signing this authorization, I readily acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the personal representative(s) named in this authorization and no longer be protected by HIPAA rules. I realize that such redisclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-healthcare professionals and otherwise cause me and my family various forms of injury.

I fully indemnify my healthcare providers for all consequences which may occur as a result of their good faith reliance and compliance with this authorization. No healthcare provider shall\ require my personal representatives to indemnify the healthcare provider or agree to perform any act in order for the healthcare provider to comply with this authorization.

CONFLICTS WITH OTHER AUTHORIZATIONS:
This authorization is in addition to other medical release authorizations I may have granted in the past or future. It does not replace them. This authorization may be relied upon by my healthcare providers regardless of any real or perceived conflict with any medical power of attorney signed by me, whether prior to or subsequent to the date of this authorization. I recognize and intend that this will result in multiple persons having the authority to obtain my protected individually identifiable health information.

This authorization is not intended to replace a medical power of attorney nor to grant any person the authority to make healthcare decisions, but merely to obtain information and explanations.