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How to Complete Your Texas Medical Power of Attorney

Medical Power of Attorney (Texas Health and Safety Code Section 166.164)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. This is Texas's statutory form for naming someone (your "agent") to make **health care decisions** for you if you become unable to. It does **not** cover financial matters. For those, use a Texas Statutory Durable Power of Attorney.

1. **Name your agent (Page 1)**
   Enter your name and the name, address, and phone number of the person you want to make health care decisions for you if you cannot. Your agent must be 18 or older.
2. **Limitations and alternates (Pages 1–2)**
   Write any limits on your agent's authority, or "None." You may name a first and second alternate agent.
3. **Read the disclosure statement (Pages 2–3)**
   Texas requires the disclosure statement to be part of the form. By signing, you confirm you have read and understood it.
4. **Sign one of two ways (Pages 4–5)**
   Sign in front of a **notary** (Page 4), or in front of **two qualified adult witnesses** (Page 5). Your agent, relatives, and your doctor cannot serve as the first witness. Many people choose the notary because finding a qualified witness is hard. We can also provide witnesses for an additional fee.

After It's Signed

- Give signed copies to your agent, alternate agents, and your doctor, and list them on Page 2.
- Your agent's authority begins only when your doctor certifies in writing that you cannot make your own health care decisions.
- You can revoke it at any time by telling your agent or health care provider. We have a free Revocation of Advance Directive form.
- Consider also completing a Directive to Physicians and a HIPAA Authorization. We have free Texas forms for both.

Need a Notary and Witnesses? We Come to You.

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Have questions about this document? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**. Main headquarters: 2315 Capitol Avenue, Sacramento, CA 95816.

This form is provided as a free convenience. First Choice Mobile Notary & Apostille is not a law firm, and a notary public who is not an attorney cannot give legal advice or help you decide what to write on this form. These instructions are general information only and are not legal advice. If you have questions about your situation, consult a licensed Texas attorney. © 2026 First Choice Mobile Notary & Apostille. All rights reserved. This form may be filled in and printed for personal use; it may not be copied, altered, or redistributed for commercial purposes.

MEDICAL POWER OF ATTORNEY

DESIGNATION OF HEALTH CARE AGENT (Texas Health and Safety Code Section 166.164)

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 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 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 | Phone

Address

B. Second Alternate Agent

Name | Phone

Address

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The original of this document is kept at:

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.

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

Ending date (optional)

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

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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.)

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SIGNATURE ACKNOWLEDGED BEFORE NOTARY

I sign my name to this medical power of attorney on

day | month, year | at (city, county, state)

X _____
(Signature)

(Print name)

NOTARY ACKNOWLEDGMENT

STATE OF TEXAS §

COUNTY OF §

This instrument was acknowledged before me on

(date) | (name of person acknowledging)

X _____
Notary Public, State of Texas

(Notary seal)

Notary's printed name

Notary ID number | My commission expires

OR, IF NOT USING A NOTARY, SIGN ON THE NEXT PAGE IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

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SIGNATURE IN PRESENCE OF TWO COMPETENT ADULT WITNESSES

I sign my name to this medical power of attorney on

day | month, year | at (city, county, state)

X _____ (Signature) | (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 of First Witness

X _____ Signature of witness | Printed name | Date

Address (street, city, state, ZIP)

SIGNATURE OF SECOND WITNESS.

X _____ Signature of witness | Printed name | Date

Address (street, city, state, ZIP)

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