DISCLOSURE STATEMENT

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

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 procedures to maintain, diagnose, or treat your physical and 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 capacity 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 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 to someone else who is knowledgeable with these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything 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 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 or 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 durable power of attorney for health care. 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 OR MORE QUALIFIED WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

(1) the person you have designated as your agent;

(2) your health or residential care provider or an employee of your health or residential care provider;

(3) your spouse, if applicable;

(4) your lawful heirs or beneficiaries named in your will or a deed; or

(5) creditors or persons who have a claim against you.

SIGN BELOW TO ACKNOWLEDGE YOUR RECEIPT OF THIS DISCLOSURE STATEMENT PRIOR TO YOUR EXECUTION OF THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND TO AFFIRM THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION CONTAINED THEREIN.

_____

JOHN A. DOE

DURABLE POWER OF ATTORNEY

FOR HEALTH CARE OF

JOHN A. DOE

STATE OF TEXAS

COUNTY OF ANYCOUNTY

DESIGNATION OF HEALTH CARE AGENT

I, JOHN A. DOE, of Anytown, Anycounty County, Texas, appoint my wife, JANE B. DOE, 1234 Main Street, Anytown, Texas 70000, (214) 000-0000 as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This Durable Power of Attorney for Health Care takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

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, to serve in the following order:

JOSEPH C. DOE
5678 Main Street
NewTown, Texas 70000
(817) 000-0000

MARY D. DOE
1234 Elm Street
Anytown, Texas 70000
(214) 999-9999

The original of this document is kept at the following location:

_____

_____

_____

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 this 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.

PRIOR DESIGNATIONS REVOKED

I revoke any prior Durable Power of Attorney for Health Care.

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.

EXECUTED this ___ day of _____, _____ at _____

_____
JOHN A. DOE, Declarant

STATEMENT OF WITNESSES

I declare under penalty of perjury that the principal has identified himself to me, that the principal signed or acknowledged this Durable Power of Attorney for Health Care in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, that I am not the person appointed agent by this document, and that I am not a provider of health or residential care, the employee of a provider of health or residential care, the operator of a community care facility, or an employee of an operator of a health care facility.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to any part of the estate of the principal on the death of the principal under a will or by operation of law.

_____
Witness

_____
Address

_____
Witness

_____
Address

STATE OF TEXAS

COUNTY OF ANYCOUNTY

BEFORE ME, the undersigned, a Notary Public in and for said County and State, on this day personally appeared JOHN A. DOE, known by me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he is an adult and that he executed the foregoing instrument for the purposes and consideration therein expressed and in the capacity therein stated.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this __ day of _____ _____.

_____
Notary Public, State of Texas

STATE OF TEXAS

COUNTY OF ANYCOUNTY

BEFORE ME, the undersigned, a Notary Public in and for said County and State, on this day personally appeared _____ and _____, each of whom declared to me that they were eighteen years of age or more and that they signed as witnesses to the foregoing instrument.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this ___ day of _____, _____.

_____
Notary Public, State of Texas

DISCLOSURE STATEMENT

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

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Your agent's authority begins when your doctor certifies that you lack the capacity 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 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 to someone else who is knowledgeable with these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything 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 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 or 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 durable power of attorney for health care. 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 OR MORE QUALIFIED WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

(1) the person you have designated as your agent;

(2) your health or residential care provider or an employee of your health or residential care provider;

(3) your spouse, if applicable;

(4) your lawful heirs or beneficiaries named in your will or a deed; or

(5) creditors or persons who have a claim against you.

SIGN BELOW TO ACKNOWLEDGE YOUR RECEIPT OF THIS DISCLOSURE STATEMENT PRIOR TO YOUR EXECUTION OF THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND TO AFFIRM THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION CONTAINED THEREIN.

_____

JANE B. DOE

DURABLE POWER OF ATTORNEY

FOR HEALTH CARE OF

JANE B. DOE

STATE OF TEXAS

COUNTY OF ANYCOUNTY

DESIGNATION OF HEALTH CARE AGENT

I, JANE B. DOE, of Anytown, Anycounty County, Texas, appoint my husband, JOHN A. DOE, 1234 Main Street, Anytown, Texas 70000, (214) 000-0000 as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This Durable Power of Attorney for Health Care takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

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, to serve in the following order:

JOSEPH C. DOE
5678 Main Street
NewTown, Texas 70000
(817) 000-0000

MARY D. DOE
1234 Elm Street
Anytown, Texas 70000
(214) 999-9999

The original of this document is kept at the following location:

_____

_____

_____

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 this 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.

PRIOR DESIGNATIONS REVOKED

I revoke any prior Durable Power of Attorney for Health Care.

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.

EXECUTED this ___ day of _____, _____ at _____

_____
JANE B. DOE, Declarant

STATEMENT OF WITNESSES

I declare under penalty of perjury that the principal has identified herself to me, that the principal signed or acknowledged this Durable Power of Attorney for Health Care in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, that I am not the person appointed agent by this document, and that I am not a provider of health or residential care, the employee of a provider of health or residential care, the operator of a community care facility, or an employee of an operator of a health care facility.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to any part of the estate of the principal on the death of the principal under a will or by operation of law.

_____
Witness

_____
Address

_____
Witness

_____
Address

STATE OF TEXAS

COUNTY OF ANYCOUNTY

BEFORE ME, the undersigned, a Notary Public in and for said County and State, on this day personally appeared JANE B. DOE, known by me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that she is an adult and that she executed the foregoing instrument for the purposes and consideration therein expressed and in the capacity therein stated.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this __ day of _____ _____.

_____
Notary Public, State of Texas

STATE OF TEXAS

COUNTY OF ANYCOUNTY

BEFORE ME, the undersigned, a Notary Public in and for said County and State, on this day personally appeared _____ and _____, each of whom declared to me that they were eighteen years of age or more and that they signed as witnesses to the foregoing instrument.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this ___ day of _____, _____.

_____
Notary Public, State of Texas