ADVANCE DIRECTIVE
and
MEDICAL POWER OF ATTORNEY

I. ADVANCE DIRECTIVE

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 providers, 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.

A. LIFE-SUSTAINING TREATMENT.

I, Client Name, 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 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:

Terminal Condition. 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 this statement reflects your desires, you must initial the statement on the line provided.)

Irreversible Condition. 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).

(If this statement reflects your desires, you must initial the statement on the line provided.)

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, 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.

B. NUTRITION AND HYDRATION. If I have a condition stated above, it is my preference NOT TO RECEIVE artificially administered nutrition and hydration (food and fluids).

C. 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 intravenous antibiotics, etc. Be sure to state whether you do or do not want the particular treatment.)

other specific requests or instructions do you wish to make?

DEFINITIONS:

"Artificial 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 stomach (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 artificial hydration and nutrition. 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.

INFORMATION CONCERNING THE MEDICAL POWER OF ATTORNEY

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.

NOTE: While Texas law requires that you be provided the disclosure statement substantially in the form which appears above, Section 166.154 of the Texas Health and Safety Code was amended in 2009 so that, in lieu of signing in the presence of the witnesses, the principal may sign the medical power of attorney on or after September 1, 2009, and have the signature acknowledged before a notary public.

II. MEDICAL POWER OF ATTORNEY

A. DESIGNATION OF HEALTH CARE AGENT. I, Client Name, appoint:

Agent Name: designate as your Agent

Address: 801 N El Paso St, STE 150
El Paso, TX 79902
Phone: Home: 9157278364 Work: 9155911959
Relation, if any: Brother

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.

It is my desire that my Agent act consistently with my wishes as stated elsewhere in this document or otherwise made known. This document gives my Agent the authority to make any health care decision I could make consistent with the law of this state and including decisions to withhold or withdraw life-sustaining procedures, but NOT including artificially administered nutrition and hydration.

NOTICE: A person may not exercise the authority of an Agent while the person serves as:
(1) the Principal's health care provider;
(2) an employee of the Principal's health care provider unless the person is a relative of the Principal;
(3) the Principal's residential care provider; or
(4) an employee of the Principal's residential care provider unless the person is a relative of the Principal.

B. LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS: any other limitations?

C. 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:

FIRST ALTERNATE AGENT

Agent Name: Alternate Agent?

Address: 801 N El Paso St, STE 150
El Paso, TX 79902
Phone: Home: 9157278364 Work: 9155911959

SECOND ALTERNATE AGENT

Agent Name: second Alternate Agent?

Address: 801 N. El Paso St, BASEMENT LEVEL
El Paso, TX 79902
Phone: Home: 9157278364 Work: 9155911959

D. 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.

E. PRIOR DESIGNATIONS REVOKED. I revoke any prior Medical Power of Attorney.

F. ACKNOWLEDGEMENT 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.

G. HIPAA RELEASE AUTHORITY

I intend for my Agent to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164.

Accordingly, I hereby authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health-care professional, dentist, optician, health plan, hospital, hospice, clinic, laboratory, pharmacy, pathologist, or other provider of medical or mental health care, as well as any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has paid for or is seeking payment from me for such services, to give, disclose and release to my Agent who is named herein and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

In determining whether I am incapacitated, all individually identifiable health information and medical records may be released to the person who is nominated as my Agent hereunder, including any written opinion relating to my incapacity that the person nominated as my Agent may have requested. This release authority applies to any information governed by HIPAA and applies even if that person has not yet begun serving as my Agent.

This authority given to my Agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to my Agent may be subject to redisclosure by my Agent and may no longer be protected by HIPAA. The authority given to my Agent herein has no expiration date and shall expire only in the event that I revoke this Medical Power of Attorney in writing and deliver it to my health-care provider. There are no exceptions to my right to revoke this Medical Power of Attorney.

IV. GENERAL PROVISIONS

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.

If any provision of this document is held to be invalid, such invalidity shall not affect the other provisions which can be given effect without the invalid provision, and to this end the directions in this document are severable.

(YOU MUST DATE AND SIGN THIS DOCUMENT)

I sign my name to this Document on _____ day of _____, _____, at El Paso, TX.

Signature: _____

Name: Client Name

THE STATE OF TEXAS

COUNTY OF EL PASO

This instrument was signed and acknowledged before me on this ____ day of _____, 20___, by Client Name.

_____
Notary Public in and for the State of Texas
My commission expires: _____