MEDICAL POWER OF ATTORNEY FOR COVID 19 OR VARIANTS

STATE OF _____ **§**
§ KNOW ALL MEN BY THESE PRESENTS
COUNTY OF _____ **§**

I, _____, appoint

Name:
Address:
Phone:

as my agent(s) to make any and all health care decisions for me, except to the extent I state otherwise in this document. The agents listed above can work together or if needed in an attorney client capacity. 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:

This Power of Attorney specifically is to be used for the limited purpose of determining treatment options associated with a Covid 19, variants or illnesses derived thereof diagnosis or for the treatment of side effects from vaccines associated with Covid 19 or its variants.

DESIGNATION OF ALTERNATE AGENT

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person to serve as my agent to make health care decisions for me as authorized by this document:

Name:
Address:
Phone:

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.

This Covid19 related Medical Power of Attorney is in effect for one year from the date of signature below.

DISCLOSURE STATEMENT.

THIS MEDICAL POWER OF ATTORNEY IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Specifically, you acknowledge that this document is intended to support your decision as a sovereign individual and your rights as a patient as described in your Advanced Directive for Covid 19. You acknowledge that all treatment options for Covid 19 have risks. You are making a conscience decision to forego the use of the ventilator and/or Remdesivir and direct your Medical Power of Attorney to seek alternative treatment options. You acknowledge that in seeking alternative treatment options there are still risks associated and there is no guarantee that you will succumb to death or suffer from serious bodily injury and only expect that your agents comply with your wishes and that they make the best decision available at the time

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 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.

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.

I sign my name to this medical power of attorney on the ____ day of _____, 2021 at_____.

_____

_____

SUBSCRIBED AND SWORN TO BEFORE ME by the said _____, Principal, this _____ day of _____, 2021.

_____
Notary Public, State of Texas

FORM PREPARED BY:
Kellye SoRelle, Attorney
Texas Bar No. 24053486
kellye@sorellelaw.com