

1 ENGROSSED SENATE  
2 BILL NO. 1094

By: Howard of the Senate

3 and

4 Stinson of the House

5  
6 An Act relating to the Oklahoma Health Care Agent  
7 Act; amending Sections 3 and 5, Chapter 136, O.S.L.  
8 2022 (63 O.S. Supp. 2022, Sections 3111.3 and  
9 3111.5), which relate to execution for power of  
10 attorney for health care and form; modifying  
11 signature requirement for power of attorney for  
12 health care; updating statutory reference; modifying  
13 certain form; and declaring an emergency.

14 BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

15 SECTION 1. AMENDATORY Section 3, Chapter 136, O.S.L.  
16 2022 (63 O.S. Supp. 2022, Section 3111.3), is amended to read as  
17 follows:

18 Section 3111.3. A. A person with capacity may give an oral or  
19 written individual instruction. The instruction may be limited to  
20 take effect only if a specified condition arises.

21 B. A person with capacity may execute a power of attorney for  
22 health care, which may authorize the agent to make any health care  
23 decision the principal could have made while having capacity other  
24 than the withholding or withdrawal of life-sustaining treatment,  
nutrition, or hydration, which may only be authorized in compliance  
with the Oklahoma Advance Directive Act; provided, however, the

1 power of attorney for health care may authorize the agent to sign a  
2 do-not-resuscitate consent in accordance with the provisions of the  
3 Oklahoma Do-Not-Resuscitate Act, Section 3131.1 et seq. of Title 63  
4 of the Oklahoma Statutes. The power shall be in writing and signed  
5 by the principal. The power remains in effect notwithstanding the  
6 principal's later incapacity and may include individual  
7 instructions. Unless related to the principal by blood, marriage,  
8 or adoption, an agent may not be an owner, operator, or employee of  
9 a residential long-term health care institution at which the  
10 principal is receiving care.

11 C. Unless otherwise specified in a power of attorney for health  
12 care, the authority of an agent becomes effective only upon a  
13 determination that the principal lacks capacity and ceases to be  
14 effective upon a determination that the principal has recovered  
15 capacity.

16 D. Unless otherwise specified in a power of attorney for health  
17 care, a determination that an individual lacks or has recovered  
18 capacity, or that another condition exists that affects an  
19 individual instruction or the authority of an agent, shall be made  
20 by the attending physician.

21 E. An agent shall make health care decisions in accordance with  
22 the principal's individual instructions, if any, and other wishes to  
23 the extent known to the agent. Otherwise, the agent shall make the  
24 decision in accordance with the agent's determination of the

principal's best interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

F. A health care decision made by an agent for a principal is effective without judicial approval.

G. A power of attorney for health care shall be signed by the principal ~~and~~ in the presence of a notary public or witnessed by two (2) individuals who are at least eighteen (18) years of age and who are not legatees, devisees, or heirs at law of the principal.

H. A power of attorney for health care is valid for purposes of this act if it is in substantial compliance with this act, regardless of when or where executed or communicated.

SECTION 2. AMENDATORY Section 5, Chapter 136, O.S.L. 2022 (63 O.S. Supp. 2022, Section 3111.5), is amended to read as follows:

Section 3111.5. The following form may, but need not, be used to create a power of attorney for health care. The other sections of this act govern the effect of this form or any other writing used to create a power of attorney for health care. An individual may complete or modify all or any part of the following form to the extent consistent with subsection B of Section ~~3~~ 3111.3 of this ~~act~~ title:

#### HEALTH CARE POWER OF ATTORNEY

1        You have the right to give instructions about your own health  
2 care. You also have the right to name someone else to make health  
3 care decisions for you. This form lets you do either or both of  
4 these things. If you use this form, you may complete or modify all  
5 or any part of it. You are free to use a different form.

6        This form is a power of attorney for health care that lets you  
7 name another individual as agent to make health care decisions for  
8 you if you become incapable of making your own decisions or if you  
9 want someone else to make those decisions for you now even though  
10 you are still capable. You may also name an alternate agent to act  
11 for you if your first choice is not willing, able, or reasonably  
12 available to make decisions for you. Unless related to you, your  
13 agent may not be an owner, operator, or employee of a residential  
14 long-term health care institution at which you are receiving care.

15        Unless the form you sign limits the authority of your agent,  
16 your agent may make all health care decisions for you. This form  
17 has a place for you to limit the authority of your agent. You need  
18 not limit the authority of your agent if you wish to rely on your  
19 agent for all health care decisions that may have to be made. If  
20 you choose not to limit the authority of your agent, your agent will  
21 have the right to:

22        1. Consent or refuse consent to any care, treatment, service,  
23 or procedure to maintain, diagnose, or otherwise affect a physical  
24 or mental condition;

1        2.    Select or discharge health care providers and facilities;

2    and

3        3.    Sign a do-not-resuscitate consent.

4        This form does not authorize the agent to make any decisions  
5    directing the withholding or withdrawal of life-sustaining  
6    treatment, nutrition, or hydration, which may only be authorized in  
7    compliance with the Oklahoma Advance Directive Act, except that this  
8    form may authorize the agent to sign a do-not-resuscitate consent.

9        After completing this form, sign and date the form at the end.

10    It is required that two other individuals sign as witnesses.    These  
11    witnesses must be at least 18 years old and not related to you or  
12    named to inherit from you.    Give a copy of the signed and completed  
13    form to your physician, to any other health care providers you may  
14    have, to any health care facility at which you are receiving care,  
15    and to any health care agents you have named.    You should talk to  
16    the person you have named as agent to make sure that he or she  
17    understands your wishes and is willing to take the responsibility.

18        You have the right to revoke this power of attorney for health  
19    care or replace this form at any time.

20                                    POWER OF ATTORNEY FOR HEALTH CARE

21        1.    DESIGNATION OF AGENT:    I designate the following individual  
22    as my agent to make health care decisions for me:

23    \_\_\_\_\_  
24        (name of individual you choose as agent)

1 \_\_\_\_\_

2 (address) (city) (state) (zip code)

3 \_\_\_\_\_

4 (home phone) (work phone)

5 OPTIONAL: If I revoke my agent's authority or if my agent is

6 not willing, able, or reasonably available to make a health care

7 decision for me, I designate as my first alternate agent:

8 \_\_\_\_\_

9 (name of individual you choose as first alternate agent)

10 \_\_\_\_\_

11 (address) (city) (state) (zip code)

12 \_\_\_\_\_

13 (home phone) (work phone)

14 OPTIONAL: If I revoke the authority of my agent and first

15 alternate agent or if neither is willing, able, or reasonably

16 available to make a health care decision for me, I designate as my

17 second alternate agent:

18 \_\_\_\_\_

19 (name of individual you choose as second alternate agent)

20 \_\_\_\_\_

21 (address) (city) (state) (zip code)

22 \_\_\_\_\_

23 (home phone) (work phone)

24 \_\_\_\_\_

1        2. AGENT'S AUTHORITY: My agent is authorized to make all  
2 health care decisions (not to include the withholding or withdrawal  
3 of life-sustaining treatment, nutrition, or hydration, other than  
4 signing a do-not-resuscitate consent) for me that I could make if I  
5 were able, except as I state here:

6 \_\_\_\_\_  
7 \_\_\_\_\_  
8 \_\_\_\_\_

9        (Add additional sheets if needed.)

10       3. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's  
11 authority becomes effective when my attending physician determines  
12 that I am unable to make my own health care decisions unless I mark  
13 the following box. If I mark this box [    ], my agent's authority  
14 to make health care decisions for me takes effect immediately.

15 \_\_\_\_\_

16        (Initials)

17       4. AGENT'S OBLIGATION: My agent shall make health care  
18 decisions for me in accordance with this power of attorney for  
19 health care and my other wishes to the extent known to my agent. To  
20 the extent my wishes are unknown, my agent shall make health care  
21 decisions for me in accordance with what my agent determines to be  
22 in my best interest. In determining my best interest, my agent  
23 shall consider the decisions I would have made myself to the extent  
24 known to my agent.

1 \_\_\_\_\_  
2 (Initials)

3 5. RELIEF FROM PAIN: Except as I state in the following space,  
4 I direct that treatment for alleviation of pain or discomfort be  
5 provided at all times, even if it hastens my death:  
6 \_\_\_\_\_  
7 \_\_\_\_\_

8 6. OTHER WISHES: (If you do not agree with any of the optional  
9 choices above and wish to write your own, or if you wish to add to  
10 the instructions you have given above, you may do so here.) I  
11 direct that:  
12 \_\_\_\_\_  
13 \_\_\_\_\_

14 (Add additional sheets if needed.)

15 7. EFFECT OF COPY: A copy of this form has the same effect as  
16 the original.

17 8. SIGNATURES: Sign and date the form here:  
18 \_\_\_\_\_  
19 (date) (sign your name)  
20 \_\_\_\_\_  
21 (address) (print your name)  
22 \_\_\_\_\_  
23 (city) (state)  
24 State of Oklahoma



County of \_\_\_\_\_

Subscribed and sworn to before me this            day of            , 20    .

Notary Public

OR

SIGNATURES OF WITNESSES:

First witness

Second witness

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(print name)
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(print name)
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(address)

(address)

(city) (state)

(city)	(state)
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(signature of witness)

(signature of witness)

(date)

(date)

SECTION 3. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

1 Passed the Senate the 28th day of February, 2023.

2  
3 \_\_\_\_\_  
4 Presiding Officer of the Senate

5 Passed the House of Representatives the \_\_\_\_ day of \_\_\_\_\_,  
6 2023.

7  
8 \_\_\_\_\_  
9 Presiding Officer of the House  
10 of Representatives