An Act

ENROLLED SENATE
BILL NO. 1094

By: Howard of the Senate

and

Stinson of the House

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

SUBJECT: Oklahoma Health Care Agent Act

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

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

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

B. A person with capacity may execute a power of attorney for health care, which may authorize the agent to make any health care decision the principal could have made while having capacity other 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 power of attorney for health care may authorize the agent to sign a do-not-resuscitate consent in accordance with the provisions of the

Oklahoma Do-Not-Resuscitate Act, Section 3131.1 et seq. of Title 63 of the Oklahoma Statutes. The power shall be in writing and signed by the principal. The power remains in effect notwithstanding the principal's later incapacity and may include individual instructions. Unless related to the principal by blood, marriage, or adoption, an agent may not be an owner, operator, or employee of a residential long-term health care institution at which the principal is receiving care.

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

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

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

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

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

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

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

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

3. Sign a do-not-resuscitate consent.

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

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

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

POWER OF ATTORNEY FOR HEALTH CARE

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

_____

(name of individual you choose as agent)

_____

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

_____

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____

(name of individual you choose as first alternate agent)

_____
(address) (city) (state) (zip code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____

(name of individual you choose as second alternate agent)

_____
(address) (city) (state) (zip code)

_____

(home phone) (work phone)

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

_____

_____

_____

(Add additional sheets if needed.)

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

_____

(Initials)

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

_____

(Initials)

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

_____

_____

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

_____

_____

(Add additional sheets if needed.)

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

8. SIGNATURES: Sign and date the form here:

_____ _____

(date) (sign your name)

_____ _____

(address) (print your name)

_____

(city) (state)

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

_____ _____

(print name) (print name)

_____ _____

(address)	(address)
_____	_____
(city) (state)	(city) (state)
_____	_____
(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.

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

_____
Presiding Officer of the Senate

Passed the House of Representatives the 24th day of April, 2023.

_____
Presiding Officer of the House
of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____ day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____ day of _____, 20_____, at _____ o'clock _____ M.

_____
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____ day of _____, 20 _____, at _____ o'clock _____ M.

By: _____