About the Health Care Proxy Form

This is an important legal document.
Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.

2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.

3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.

4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.

5. You do not need a lawyer to fill out this form.

6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.

7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

9. Even though you have signed this form, 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 if you object, nor will your agent have any power to object.

10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.

11. Appointing a health care agent is voluntary. No one can require you to appoint one.

12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

New York Health Care Proxy

(1) I, _____, hereby appoint:

Agent's Name: _____

Agent's Home Address: _____

Agent's Telephone Numbers: _____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint:

Alternate's Name: _____

Alternate's Home Address: _____

Alternate's Telephone Numbers: _____

(3) Unless I revoke it, this proxy shall remain in effect indefinitely or until the date or condition I have stated below. (Optional: If you want this proxy to expire, state the date or conditions here.) This proxy will expire **(specify date or conditions):**

_____

_____

(4) Optional Instructions: I direct my agent to make health decisions in accordance with my wishes and limitations as stated below, or as he or she otherwise knows. **(attach additional pages as necessary)**

_____

_____

My agent knows my wishes regarding artificial nutrition and hydration.

(5) Your Identification (please print)

Your Name: _____

Your Signature: _____ Date: _____

Your Address: _____

(6) Optional: Organ and/or Tissue Donation

Upon my death, I wish to donate my organs, tissues or body parts: (check any that apply and note limitations)

_____ Any needed organs and/or tissues

_____ Only the following organs and/or tissues:

_____

My donation is for the following:

___transplant ___therapy ___research ___education ___any use

Your Signature: _____ Date: _____

(7) Statement by Witnesses (Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)

I declare that the person who signed this document is known to me and appears to execute this proxy willingly and of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Name of Witness 1 (please print): _____ Date: _____

Signature: _____

Address: _____

Name of Witness 2 (please print): _____ Date: _____

Signature: _____

Address : _____