# Health Care Proxy Form

## Making decisions about your health

Whether to accept or reject medical care in an end-of-life situation is a very personal decision governed by your beliefs. Should a serious accident or illness leave you unable to relay your wishes, you need to ensure they are honored. In New York State, that means having a living will or health care proxy.

You can complete the attached health care proxy for your records. Once completed, hospitals, doctors, and other health care providers must follow your agent's decisions as if they were your own.

**1.** I, _____ hereby appoint _____
(name, home address and phone number)

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 when and if I become unable to make my own health care decisions.

**2.** **Optional: Alternate Agent.** If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint:

_____
(name, home address and telephone number)

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

**3.** Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (**Optional:** If you want this proxy to expire, state the date or conditions here.)

This proxy shall expire (specify date or conditions): _____

_____

**4.** **Optional:** I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary).

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section.

**5.** **Your Identification (print):** Your Name _____

Your Signature _____ Date _____

Your Address _____

**6.** **Optional: Organ and/or Tissue Donation.** I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)

Any needed organs and/or tissues _____

The following organs and/or tissues _____

Limitations _____

_____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

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 personally known to me and appears to be of sound mind and acting 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.

Witness 1 (print): _____ Date _____

Witness 1 Signature: _____

Address: _____

Witness 2 (print): _____ Date _____

Witness 2 Signature: _____

Address: _____

## After signing your proxy

Give a copy to your agent, doctor, attorney and family members or close friends. Keep a copy with your important papers. You can contact my district office for more information. Do not put it in a location where no one else can get to it, like a safe deposit box. Be sure to bring a copy with you if you are admitted to the hospital, even for minor or out-patient surgery.