

Health Care Proxy

(1) 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. This proxy shall take effect only 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) 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):

Please note that 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 the above section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) I also grant authority and power to my agent(s) to serve as my personal representative for purposes of the Health Insurance Portability and Accountability Act (HIPAA). My agent is authorized to execute any and all releases and other documents necessary in order to obtain disclosure of my patient records and other medical information subject to and protected by HIPAA.

(6) Your Identification (please print)

Name _____

Signature _____ Date _____

Address _____

(7) Witnesses: Two 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 appeared to execute the Health Care Proxy willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1:

Witness 2:

Name (*please print*): _____

Name (*please print*): _____

Signature: _____

Signature: _____

Address: _____

Address: _____

Date: _____

Date: _____