

## Health Care Proxy and Living Will

### Signing Instructions

- This document must be signed in front of two witnesses
- **Before signing this document fill in all of your personal information and your agent's personal information highlighted in yellow; it is not necessary to designate a successor agent (just leave the successor information blank if there is no successor)**
- Once you are ready to sign this document in the presence of two witnesses, **date and sign the Health Care Proxy and Living Will on page 4 in the areas highlighted in green**
- Thereafter, the witnesses should read the declaration on page 5 and sign and print their names and addresses on page 5
- Once the document is signed, keep it in a safe, fire-proof, place, but do not put it in a bank safe deposit box
- If possible, give a copy to your agent and let your agent know where the original is kept
- **DO NOT ALTER THE WORDING OF THIS DOCUMENT**

**HEALTH CARE PROXY  
- and -  
LIVING WILL**

I, \_\_\_\_\_, residing at \_\_\_\_\_,

declare this to be my health care proxy and living will.

1. I appoint as my primary health care agent:

**Agent's Name:** \_\_\_\_\_

**Residence Address:** \_\_\_\_\_  
\_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Relationship (if any):** \_\_\_\_\_

2. If my attending physician shall determine that my primary health care agent is not reasonably available, willing and competent to serve and is not expected to become reasonably available, willing and competent to make a timely decision given my medical circumstances, I appoint as my alternate health care agent:

**Alternate's Name:** \_\_\_\_\_

**Residence Address:** \_\_\_\_\_  
\_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Relationship (if any):** \_\_\_\_\_

3. All references below to my Agent are to the primary or alternate health care agent then acting.

4. If my attending physician determines that I am unable to make my own health care decisions, my Agent shall have the authority to make any and all health care decisions on my behalf which I could have made if I then possessed the capacity to make such decisions. My Agent shall make such decisions in accordance with my wishes known to my Agent or, if my

wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with my best interests.

5. My Agent's authority to make health care decisions for me includes, without limitation, the authority to direct the withholding or withdrawal of artificial, life-sustaining procedures and medications, including artificial nutrition and hydration.

6. In making health care decisions involving the withholding or withdrawal of life-sustaining procedures or medications, my Agent shall be guided by the following:

-- I direct that if I am afflicted with an illness or suffer an injury which is terminal and there is no reasonable expectation that I shall substantially regain the ability to live a meaningful, sentient, and personally responsible life, I shall be allowed to die naturally and with dignity and that no artificial life-sustaining procedures or medications, including, without limitation, artificial nutrition and hydration, be employed to keep me alive, or if such procedures or medications have been employed in the course of my care or treatment, that they be withdrawn. "Terminal" refers to a condition which, without the administration of life-sustaining procedures or medications, will, in the opinion of my attending physician, result in death within a relatively short time. No inference shall be drawn from the foregoing which would limit my Agent's authority to withhold or withdraw life-sustaining procedures or medications, or to employ such procedures or medications, under circumstances other than those just described.

-- I ask that medication be mercifully administered to me to alleviate suffering even though that may shorten my remaining life.

-- I wish to live out my last days at home rather than in a hospital, nursing home, or other health care institution, if that would not impose an undue burden upon my family.

7. If both my primary and alternate health care agents are unable, unwilling or unavailable to act, or if this health care proxy is not given legal effect in the relevant jurisdiction, I earnestly request that my directions and wishes set forth in Paragraph 6 be construed and carried out as my "living will," which I have made after careful and competent consideration and in accordance with my strong convictions and beliefs.

8. I authorize my Agent to receive all medical information and medical, clinical, and other records necessary to make informed decisions regarding my health care, to have access to all such records relating to the provision of my health care, and to have all my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release of authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka "HIPAA"), 42 USC 1320d and 45 CFR 160-164 and by providing this release, my Agent is acting as my personal representative pursuant to HIPAA.

9. On behalf of myself, and my heirs and legal representatives, and all persons who in any way might claim under or through me, I hereby release from criminal and civil liability, and waive any claim against, (i) my Agent for making a health care decision in good faith pursuant to this health care proxy and (ii) all persons (including any institutions) providing health care to me for honoring in good faith a health care decision made by my Agent or, if both my primary and alternate health care agents are unable, unwilling or unavailable to act, for carrying out the terms of my living will set forth in Paragraph 6.

10. I hereby revoke all health care proxies and living wills which I may have made previously. Unless revoked, this health care proxy and living will shall remain in effect indefinitely.

11. I intend this instrument to have effect in any jurisdiction in which I may be present. However, in construing this health care proxy, the definitions and procedures set forth in Article 29-C of the Public Health Law of New York shall apply except to the extent that the law of another jurisdiction is controlling and requires a different result.

12. Any invalid, ineffective, or unenforceable provision of this instrument shall not affect any of its other provisions or the appointment of my Agent.

12. This health care proxy and living will shall be executed as a single, original instrument and shall not be executed in counterparts.

14. I fully understand the purpose and effect of this instrument and sign it after careful deliberation.

**Dated:** \_\_\_\_\_, 2020

**PRINCIPAL signs here: ==>** \_\_\_\_\_

Each of the undersigned **witnesses** declares that:

1. The person who signed this document did so in my presence and in the presence of the other witness;

2. Such person is personally known to me and appears to be eighteen (18) years of age or older, of sound mind, and acting willingly and free from duress or undue influence; and

3. I am eighteen (18) years of age or older and am not designated as such person's health care agent.

**Witness Signature:** \_\_\_\_\_

**Please print name and address here:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Witness Signature:** \_\_\_\_\_

**Please print name and address here:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_