Health Care Proxy

An Informational and Educational Guide for Residents of New York State.

Designed and Provided by the Rural Law Center of New York, Inc.

You may contact the Rural Law Center of New York, Inc. as follows:

BY MAIL: 22 U.S. Oval, Suite 203, Plattsburgh, New York 12903
PHONE: (518) 561-5460
FAX: (518) 561-5468

OR VISIT OUR WEBSITE: www.rurallawcenter.org

Your Health Care Proxy Form

A GUIDE DESIGNED AND PREPARED BY
THE RURAL LAW CENTER OF NEW YORK, INC.

THIRTEEN IMPORTANT QUESTIONS

1. What is a HEALTH CARE PROXY FORM?

A HEALTH CARE PROXY FORM is a document that specifies your wishes for how you want to be treated if you are so seriously ill that you cannot make these decisions yourself.

2. What is a HEALTH CARE PROXY?

A HEALTH CARE PROXY is the legal term for the person that you designate to make your health care decisions when you are no longer able to do so.

3. What is the difference between a HEALTH CARE PROXY FORM, a HEALTH CARE AGENT FORM and a LIVING WILL?

Essentially, nothing. They are all terms for a document that specifies your wishes in the event of incapacitation.

4. Why do I need a HEALTH CARE PROXY?

You have a right to decide what kind of medical treatment you want or what kind of medical treatment you don't want. If you are seriously ill and unable to communicate your wishes, a HEALTH CARE PROXY can make decisions according to your wishes. But, you should state your wishes in an approved HEALTH CARE PROXY FORM.

5. Should I talk to my doctor about this?

Absolutely. Your HEALTH CARE PROXY FORM will be a helpful guide to anyone who is involved in your health care. Your doctor has an obligation to listen to your wishes and to honor them. Make sure your doctor knows that you have made your wishes clear in this document. In order for your doctor, or any other doctor treating you, to comply with your decisions about treatment, he or she needs to know.

6. Who can be a HEALTH CARE PROXY?

Anyone you choose, who is over 18 years of age, can be your HEALTH CARE PROXY. However, that person should not be your health care provider, an employee of your provider, or the owner of the care facility where you are being treated.

7. Who Should I choose to be my HEALTH CARE PROXY?

The person you choose should be someone you know and trust, as well as someone who will be able to make difficult decisions. While a close relative may be the obvious choice, you should consider whether that person may be too emotionally involved to follow your wishes. Another thing to consider, if possible, is the choice of someone who lives in the same general area that you do. No matter who you choose, be sure to discuss this fully with them and get his or her consent before completing the formal document.

8. Should I choose an alternate?

Yes. In the event that the person you have designated is not able to serve, or continue to serve as your HEALTH CARE PROXY, you should name someone who would be your next choice.

9. Can I control the decisions my HEALTH CARE PROXY MAKES?

Yes. In your HEALTH CARE PROXY FORM you can specify exactly what medical care and procedures you want and don't want. For example, you may specify your wishes about hospital admissions, health care workers, tests, surgery, medications, and treatments. You may also direct your HEALTH CARE PROXY to refuse treatment, life-sustaining machinery or artificial nutrition and hydration, if you so desire. In order to be sure that your wishes are followed, be certain to make this part of your document very clear and detailed.

10. What if I change my mind?

If you wish to make changes concerning your HEALTH CARE PROXY FORM, you should first revoke your original in writing and, if possible, destroy all copies. Make sure that your family and health care providers are informed of the change and, if necessary, have copies of the new document.

11. Do I need a Lawyer to write my HEALTH CARE PROXY FORM?

You may decide that you feel more confident if a lawyer prepares your HEALTH CARE PROXY FORM. However, if you choose to do your own HEALTH CARE PROXY FORM, you must be sure to follow New York State required procedures for signatures and witnesses.

12. What are the technical requirements of a HEALTH CARE PROXY FORM?

In New York State, a Health CARE PROXY FORM must be signed and dated by the person writing it. It must also be signed and dated by two witnesses.

13. Once it is signed, what do I do with my HEALTH CARE PROXY FORM?

Make several copies of your completed HEALTH CARE PROXY FORM. You should give a copy to your Physician and a copy to the person you named as your Health Care Proxy. You may also want to give copies to your attorney and to close friends or family members. You should keep the original for yourself in a safe place. If a copy does not fit in your purse or wallet, you should have a card in your wallet giving information regarding the existence and location of your HEALTH CARE PROXY FORM.

SAMPLE

THE RURAL LAW CENTER OF NEW YORK, INC.

HEALTH CARE PROXY

OF JANE DOE

1. CREATION OF A HEALTH CARE AGENT

To my family, relatives, friends, and my physicians, health care providers, community care facilities and any other person who may have an interest or duty in my medical care or treatment: I, **JANE DOE**, residing at 4673 South Street in Albany, New York, being of sound mind, willfully and voluntarily intend to appoint by this document a health care agent who is designated to make health care decisions for me in the event I become incapacitated and am unable to make health care decisions for myself.

2. DESIGNATION OF A HEALTH CARE AGENT

The person designated to be my health care agent in the event I become incapacitated is my sister, **SALLY DOE**, residing at 123 Fourth Street in Albany, New York and whose telephone number is (518) 555-1234. If for any reason she shall fail to serve or ceases to serve as my health care agent, my niece, **ANN DOE**, residing at 567 Eighth Street in Albany, New York and whose telephone number is (518) 555-5678, shall be my health care agent.

3. EFFECT OF INCAPACITY

This health care proxy shall become effective in the event I become incapacitated an am unable to make health care decisions for myself, in which case it shall become effective as of the date of the written statement by a physician, as provided in Paragraph 4.

4. DETERMINATION OF INCAPACITY

The determination that I have become incapacitated and am unable to make health care decisions shall be made in writing by a licensed physician. In the event that a licensed physician has made a written determination that I have become incapacitated and I am not able to make health care decisions for myself, that written statement shall be attached to the original document of this health care proxy.

5. AUTHORITY OF MY HEALTH CARE AGENT

My health care agent shall have all lawful authority permissible to make health care decisions for me, including the authority to consent, or withdraw consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition, EXCEPT, if at any time I should have an incurable injury, disease or illness, which is a terminal

condition, and the application of life sustaining procedures or machinery would serve only to artificially prolong the moment of my death, I direct that such procedures or machinery not be used, and that I be permitted to die naturally and I further direct that my health care agent take all actions necessary to allow me to die such a natural death. I specifically direct that should I have an incurable injury, disease or illness, which is a terminal condition, I do not wish to have artificial nutrition and hydration used as a treatment.

6. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

My health care agent shall have the power and authority to:

a. Review any information, verbal, or written, pertaining to my physical or mental health, including, but not limited to medical and hospital records.
b. Execute on my behalf any releases or other documents that may be required in order to obtain this information.

7. SIGNING DOCUMENTS, WAIVERS, OR RELEASES

Where necessary to implement the health care decisions that my health care agent is authorized by this document to make, my health care agent has the power to execute on my behalf documents affiliated with "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice", as well as any necessary waiver or release of liability required by a hospital or physician.

8. VISITATION

I authorize my health care agent to make all permitted decisions regarding who shall be permitted to visit me in the hospital.

9. DURATION

I intend that this Health Care Proxy remain effective until my death, or until revoked by me in writing.

Executed this _____ day of _____200__ in Albany, New York.

_____

JANE DOE

WITNESSES

I declare that the principal is personally known to me, and appears to be of sound mind and acting of her own free will. She signed this document in my presence.

WITNESS 1. _____

_____
(print name here)

Address _____

_____

WITNESS 2. _____

_____
(print name here)

Address _____

_____