# New York Health Care Proxy

(1) I, ______________________________________________

hereby appoint ______________________________________________
*Full 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 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 ______________________________________________
*Full 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.

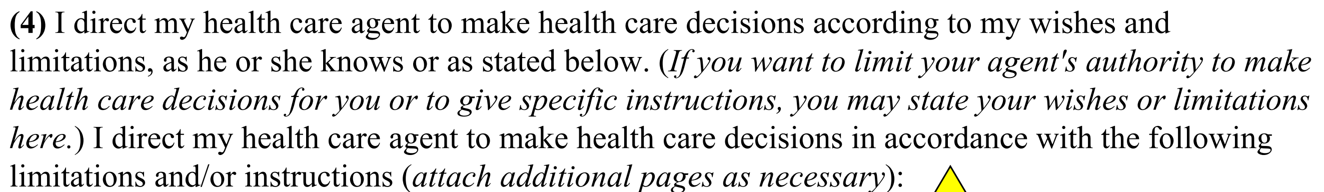
**(3)** Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire (*specify date or conditions)*:

______________________________________________

______________________________________________

______________________________________________

**(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*)

**Your Name** ______________________________________________

**Your Signature** ______________________________ **Date** ______________

**Your Address** ______________________________________________

______________________________________________

**(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/her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date: ____________________

Name of Witness 1

(print) ________________________

Signature ________________________

Street: ________________________

City, St. ________________________

Date: ____________________

Name of Witness 2

(print) ________________________

Signature ________________________

Street: ________________________

City, St. ________________________

**(8) Optional: Organ and/or Tissue Donation**

I, ______________________________ hereby make an anatomical gift, to be effective upon my death, of (*Initial*):
(*print name)*

[ ] Any organs and/or tissues

[ ] The following organs and/or tissues:

_____________________________________________________________________________

_____________________________________________________________________________

[ ] Limitations

_____________________________________________________________________________________

___________________________________________________________________

If you do not state your wishes or instructions regarding organ and/or tissue donation on this form, it will not 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.

Signed _____________________________________ Date: __________________________

Address: ________________________________________________________________________