

# Health Care Proxy

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## *Appointing Your Health Care Agent in New York State*

*The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend – to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.*

# 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) 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. 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) Your Identification** *(please 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.

Date \_\_\_\_\_ Date \_\_\_\_\_

Name of Witness 1 *(print)* \_\_\_\_\_ Name of Witness 2 *(print)* \_\_\_\_\_

Signature \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_

State of New York  
George E. Pataki, Governor  
Department of Health  
Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner