HEALTH CARE PROXY

(1) I, _____, residing at _____

(2) _____,hereby appoint _____,
residing at, _____,
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 when and if I become unable to make my own health care decisions.
My agent may review my medical records, and execute releases of confidential information from medical providers and insurers or other third party payers, and consult with my physicians and other health care personnel and providers, and shall be considered my personal representative for health care disclosure under applicable Federal HIPAA regulations, including with limitation, designation of my agent as my personal representative as defined in 45 CFR §164.502. This authorization and consent to disclosure shall apply whether or not I continue to have the capacity to give informed consent. I consent to and direct covered entities to provide my protected health information to my agent.

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)

_____

(Unless your agent knows your wishes about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration.)

(3) Name of substitute or fill-in agent if the person I appoint above is unable or unwilling or unavailable to act as my health care agent.
_____, residing at _____
telephone number, _____.
_____, residing at _____
telephone number, _____.

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific date or conditions if desired): _____

(5) Signature_____
Address: _____
_____
Date: _____

Statement by Witnesses (must be 18 or older)
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.

Witness 1_____

Address: _____

Witness 2_____

Address: _____

Health Care Proxy Form Distributed by:

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Please feel free to contact me if you have any questions completing this health care proxy or to discuss other legal matters.
Complimentary Elder Law Consultations to Veterans & AARP members