

FOR MORE INFORMATION, contact the patient representative at your local hospital.



Healthcare Association
of New York State



distributed by

NAME

for

HEALTH CARE PROXY

FOLD HERE

Special Instructions (*include any limitations you wish to impose on your agent's decision-making powers here*):

FOLD HERE

In order for your agent to make decisions about artificial nutrition and hydration (providing water and nourishment by feeding tube and intravenous line), he/she must reasonably know your wishes. You may include those wishes here.

HEALTH CARE PROXY

I, _____, of

STREET

CITY

STATE

DAYTIME PHONE

EVENING PHONE

hereby appoint _____, of

STREET

CITY

STATE

DAYTIME PHONE

EVENING PHONE

as my health care agent to make all health care decisions for me if I become unable to decide for myself and, if my agent knows my wishes, decisions about artificial nutrition and hydration. This proxy will remain in effect indefinitely, unless I revoke it or state an expiration date or expiration circumstances (see special instructions).

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.

SIGNATURE (PROXY INITIATOR)

DATE