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

Healthcare Association
of New York State

distributed by

NAME

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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**