

## **Appointing a Healthcare Proxy in New York State**

New York State Health 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.

To appoint a proxy, fill out the Health Care Proxy document on the following page, sign it, date it, and have two witnesses sign and date it. *Your agent may not be a witness to the document.*

Your agent can be any adult who is over the age of 18 or a minor who has married or is the parent of a child.

If you should ever change your mind about the wishes stated in your proxy or about the person you have designated to be your agent, you can revoke your proxy at any time by advising your health care provider(s) or your hospital verbally or in writing.

You can name an alternative agent when you sign your proxy, so if your agent cannot be contacted, the alternative agent can make decisions.

Talk to the person who is named as your agent, and give the agent a *copy* of the form. Give *copies* to your doctors and to any hospital or nursing home in which you are a patient. *Be prepared to show them the original document.* Tell family and those closest to you about the proxy and give them *copies*. Retain the original and a list of all parties to whom you have given copies so you can inform them all if you change who you list as agent(s) or revoke the proxy.

## New York State Health Care Proxy Form

1. I, (print first and last name) \_\_\_\_\_ hereby appoint

(name) \_\_\_\_\_ (home address) \_\_\_\_\_ (phone) \_\_\_\_\_

as my health care agent to make any and all health care related care decisions for me, except to the extent that I have stated otherwise. (Your agent can be any adult who is over the age of 18 or a minor who has married or is the parent of a child.) This proxy shall take effect when and if I become unable to make my own health care decisions.

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 page(s) 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 alternative agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent:

(name) \_\_\_\_\_ (home address) \_\_\_\_\_ (phone) \_\_\_\_\_

4. Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated here. (This proxy shall expire on this specific date or upon the following condition)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

### Statement by Witnesses

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: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

Witness 2: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_