

# NEW YORK HEALTH CARE PROXY/LIVING WILL

I, \_\_\_\_\_, residing at \_\_\_\_\_, being of sound mind do hereby appoint \_\_\_\_\_, residing at \_\_\_\_\_, as my health care agent to make any and all health care decisions for me except to the extent I state otherwise.

A. I hereby declare and make known to my family, physician and others, my instructions and wishes for my future health care. I direct that all health care decisions, including decisions to accept or refuse any treatment, service or procedure used to diagnose, treat or care for my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures, be made in accordance with any wishes as expressed in this document. This instruction directive shall take effect in the event that I become temporarily or permanently unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations. I direct that this document become part of my permanent medical records.

B. GENERAL INSTRUCTIONS. To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care:

Initial ONE of the following two statements with which you agree:

1. \_\_\_\_\_ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition.

OR

2. \_\_\_\_\_ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued for the purpose of allowing me to die naturally. I recognize that this is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures.

If you have initialed statement 2, please initial each of the statements (a, b, c) with which you agree:

a. \_\_\_\_\_ I realize that there may come a time when I am diagnosed as having an incurable or irreversible illness, disease or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is terminal, I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued even if the result is to hasten my death. I also direct that I be given all care necessary to make me comfortable and to relieve pain.

b. \_\_\_\_\_ If there should come a time when I become permanently unconscious, and it

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is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my capacity for interaction with other people and my surroundings, I direct that life-sustaining measures be withheld or discontinued. I direct that I be given all care necessary to provide for my personal hygiene and dignity.

c. \_\_\_\_\_ I realize that there may come a time when I am diagnosed as having an incurable or irreversible illness, disease or condition which may not be terminal. My condition may cause me to experience severe and progressive physical and mental deterioration and/or a permanent loss of significant functional capacities and faculties. If, in the course of my medical care, the burdens of continued life with treatment become greater than the benefits I experience, I direct that life-sustaining measures be withheld or discontinued even if the result is to hasten my death. I also direct that I be given all care necessary to make me comfortable and to relieve pain.

C. ARTIFICIALLY PROVIDED FLUIDS AND NUTRITION. In the circumstances initialed in paragraph B2, I also direct that artificially provided fluids and nutrition:

\_\_\_\_\_ be withheld or withdrawn and that I be allowed to die.  
\_\_\_\_\_ be provided to the extent necessary.

D. This health care proxy shall take effect in the event I become unable to make my own health care decisions.

E. In the event that the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint, residing at \_\_\_\_\_, as my health care agent.

F. DONATIONS OF ORGANS AT DEATH: Upon my death:

[\_\_\_\_\_] I **do not** wish to donate my organs, tissues or parts.  
[\_\_\_\_\_] I **do** wish to be an organ donor and upon my death I wish to donate:

[\_\_\_\_\_] (a) Any needed organ, tissue, or parts;

**or**

[\_\_\_\_\_] (b) The following organs, tissues, or parts

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

[\_\_\_\_\_] (c) My gift is for the following purposes:  
(put a line through any of the following you do not want)

- (i) Transplant
- (ii) Therapy
- (iii) Research
- (iv) Education

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G. I understand that unless I revoke it, this proxy will remain in effect indefinitely.

H. Notwithstanding the above, my agent shall have access at any time to my medical records and protected health information.

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

That the person who signed or asked another to sign this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. signed this document in my presence. I am not the person appointed as agent by this document.

Witness:

Address:

Witness:

Address:

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Notary Public

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