HEALTH CARE PROXY

PATIENT INFORMATION:

Patient Full Name: ______________________ Date of Birth: ______________________

Patient Address: ______________________ City: __________ State: ____ Zip: ________

Home Phone: ______________________ Work Phone: ______________________

E-mail Address: ____

I APPOINT AS MY HEALTH CARE AGENT:

Full Name: ______________________ E-mail Address: ______________________

Address: ______________________ City: __________ State: ____ Zip: ________

Home Phone: ______________________ Work Phone: ______________________

to have authority to make health care decisions on my behalf.

I APPOINT AS MY ALTERNATE HEALTH CARE AGENT:

Full Name: ______________________ E-mail Address: ______________________

Address: ______________________ City: __________ State: ____ Zip: ________

Home Phone: ______________________ Work Phone: ______________________

to have authority to make health care decisions on my behalf, when the designated Health Care Agent is not available, willing or competent to serve and is not expected to become available, willing or competent to make a timely decision given my medical circumstances, or, the designated Health Care Agent is disqualified from acting on my behalf because of other circumstances.

LIMITATIONS ON HEALTH CARE AGENT'S AUTHORITY:

The following describes the limitations, if any, that I have placed on the agent's authority:

____

____

____

PATIENT'S SIGNATURE: ______________________ **Date and Time:** ______________

Signed at the Direction of the Patient: ______________________ **Date and Time:** ______________

WITNESSED BY:

I, *[name:]* ______________________, affirm that the patient appeared to be at least 18 years old, of sound mind and under no constraint or undue influence. I affirm that I am at least 18 years old and have not been named as a Health Care Agent in this Health Care Proxy.

Signature: ______________________ **Date and Time:** ______________________

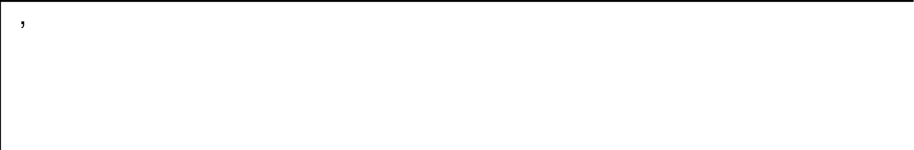
WITNESSED BY:

I, *[name:]* ______________________, affirm that the patient appeared to be at least 18 years old, of sound mind and under no constraint or undue influence. I affirm that I am at least 18 years old and have not been named as a Health Care Agent in this Health Care Proxy.

Signature: ______________________ **Date and Time:** ______________________

Effective Date of Agent's Authority: The agent's authority shall become effective if it is determined by the attending physician, according to accepted standards of medical judgment, that I lack the capacity to make or communicate health care decisions. This determination shall be set forth in writing in my permanent medical record and shall contain the attending physician's opinion regarding the cause and nature of my incapacity as well at its extent and probable duration.

PATIENT INFORMATION



HEALTH CARE PROXY ADDENDUM

To My Family, Doctors, and All those Concerned with My Care:

I, ____, residing at ______________________________

____,
make this statement to express my wishes regarding the withholding or withdrawal of life support should a time come when, as determined by my doctor, I am unable to participate in decisions regarding my health care.

Should a time come when there is no expectation of my recovery from physical or mental disability or disease, I direct that I be allowed to die with dignity, and that my doctor withhold or withdraw treatment that merely prolongs life and is unlikely to offer a cure or remission of the disease. I direct that my treatment be limited to measures that will keep me comfortable and relieve pain.

These directions are made after careful consideration and in accordance with my strong convictions and beliefs. I expect my family, doctor, and others concerned with my care to abide by my wishes and in doing so, to be free of any legal or moral liability.

Additional Instructions/Comments:

____

____

____

____

____

PATIENT'S SIGNATURE: ____________________________________ **Date and Time:** ___________________

Signed at the Direction of the Patient: ____________________________ **Date and Time:** ___________________

WITNESSED BY:

I, *[name:]* ____, affirm that the patient appeared to be at least 18 years old, of sound mind and under no constraint or undue influence. I affirm that I am at least 18 years old and have not been named as a Health Care Agent in this Health Care Proxy.

Signature: _____________________________________ **Date and Time:** _______________________________

WITNESSED BY:

I, *[name:]* ____, affirm that the patient appeared to be at least 18 years old, of sound mind and under no constraint or undue influence. I affirm that I am at least 18 years old and have not been named as a Health Care Agent in this Health Care Proxy.

Signature: _____________________________________ **Date and Time:** _______________________________

0000000

70132

00000000

PATIENT INFORMATION

,