MASSACHUSETTS HEALTH CARE PROXY

Information, Instructions, and Form

What does the Health Care Proxy Law allow?

The **Health Care Proxy** is a simple legal document that allows you to name someone you know and trust to make health care decisions for you if, for any reason and at any time, you become unable to make or communicate those decisions. It is an important document, however, because it concerns not only the choices you make about your health care, but also the relationships you have with your physician, family, and others who may be involved with your care. Read this and follow the instructions to ensure that your wishes are honored.

Under the Health Care Proxy Law (Massachusetts General Laws, Chapter 201D), any competent adult 18 years of age or over may use this form to appoint a Health Care Agent. You (the "Principal") can appoint anyone EXCEPT the administrator, operator, or employee of a health care facility such as a hospital or nursing home where you are a patient or resident UNLESS that person is also related to you by blood, marriage or adoption.

What can my Health Care Agent do?

Your Agent will make decisions about your health care **only** when you are, for some reason, unable to do that yourself. This means that your Agent can act for you if you are temporarily unconscious, in a coma, or have some other condition in which you cannot make or communicate health care decisions. Your Agent cannot act for you until your physician determines, in writing, that you lack the ability to make health care decisions. Your physician will tell you of this if there is any sign that you would understand it.

Acting with your authority, your Agent can make any health care decision that you could, if you were able. If you give your Agent full authority to act for you, he or she can consent to or refuse any medical treatment, including treatment that could keep you alive.

Your Agent will make decisions for you only after talking with your physician or health care provider, and after fully considering all the options regarding diagnosis, prognosis, and treatment of your illness or condition. Your Agent has the legal right to get any information, including confidential medical information, necessary to make informed decisions for you.

Your Agent will make health care decisions for you according to your wishes or according to his/her assessment of your wishes, including your religious or moral beliefs. You may wish to talk first with your physician, religious advisor, or other people before giving instructions to your Agent. It is very important that you talk with your Agent so that he or she knows what is important to you. If your Agent does not know what your wishes would be in a particular situation, your Agent will decide based on what he or she thinks would be in your best interest. After your physician has determined that you lack the ability to make health care decisions, if you still object to any decision made by your Agent, your own decisions will be honored unless a Court determines that you lack capacity to make health care decisions.

Your Agent's decisions will have the same authority as yours would, if you were able, and will be honored over those of any other person, except for any limitation you yourself made, or except for a Court Order specifically overriding the Proxy.

How do I fill out the form?

1. At the top of the form, print your full name and address. Print the name, address, and phone number of the person you choose as your Health Care Agent. (**Optional**: If you think your Agent might not be available at any future time, you may name a second person as an Alternate. Your Alternate will be called if your Agent is unwilling or unable to serve.)

2. Setting limits on your Agent's authority might make it difficult for your Agent to act for you in an unexpected situation. If you want your Agent to have full authority to act for you, leave the limitations space blank. If, however, you want to limit the kinds of decisions you would want your Agent or Alternate to make for you, include them in the blank.

3. **BEFORE** you sign, be sure you have two adults present who can witness you signing the document. The only people who cannot serve as witnesses are your Agent and Alternate. Then sign the document yourself. (Or, if you are physically unable, have someone else sign at your direction. The person who signs your name for you should put his/her name and address in the spaces provided.)

4. Have your witness fill in the date, sign their names and print their names and addresses.

5. **OPTIONAL**: On the back of the form are statements to be signed by your Agent and any Alternate. This is not required by law, but is recommended to ensure that you have talked with the person or persons who may have to make important decisions about your care and that each of them realizes the importance of the task they may have to do.

Who should have the original and copies?

After you have filled in the form, remove this information page and make at least four photocopies of the form. Keep the original yourself where it can be found easily (not in your safe deposit box). Give one copy to your physician who will put it in your medical record. Give copies to your Agent and any Alternate. You can give additional copies to family members, your clergy and/or lawyer, and other people who may be involved in your health care decision making.

How can I revoke or cancel the document?

Your Health Care Proxy is revoked when any of the following four things happen:

1. You sign another Health Care Proxy later on.
2. You legally separate from or divorce your spouse and your spouse is named in the Proxy as your Agent.
3. You notify your Agent, your physician, or other health care provider, orally or in writing, that you want to revoke your Health Care Proxy.
4. You do anything else that clearly shows you want to revoke the Proxy, for example, tearing up or destroying the Proxy, crossing it out, telling other people, etc.

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1. I,____, residing at___________________________

(Principal – PRINT your name)

____

(Street) (City/town) (State)

appoint as my **Health Care Agent**:____

(Name of person you choose as Agent)

of

____

(Street) (City/town) (State) (Phone)

(**OPTIONAL**: If my Agent is unwilling or unable to serve, then I appoint as my **Alternate**:

____, of___________________________________

(Name of person you choose as Alternate)

____.)

(Street) (City/town) (State) (Phone)

2. My Agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list the limitations, **if any**, you wish to place on your Agent's authority):

I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original.

3. Signed: ____

Complete only if Principal is physically unable to sign: I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

____

(Name) (Street) (City/town) (State)

4. **WITNESS STATEMENT**: We, the undersigned, each witness the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate in this document. In our presence this _________ day of __________________________, 20_______.

Witness #1:____________________________________ Witness #2:____

Name (print):___________________________________ Name (print):____

Address:________________________ Address:________________________

________________________ ________________________

5. **Statements of Health Care Agent and Alternate (OPTIONAL)**

Health Care Agent: I have been named by the Principal as the Principal's **Health Care Agent** by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, soldiers' home or other health facility where the Principal is currently a patient or resident or has applied for admission. Or, if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal's wishes.

(Signature of **Health Care Agent**): ________________________________

Alternate: I have been named by the Principal as the Principal's **Alternate** by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, soldiers' home or other health facility where the Principal is currently a patient or resident or has applied for admission. Or, if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal's wishes.

(Signature of **Alternate**): ________________________________