HEALTH CARE PROXY

(General Laws of Massachusetts, Chapter 201D)

EXPLANATION

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding anatomical gifts and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it.

Part 1 of this form is a Designation of Health Care Agent. Part 1 lets you name another individual as Agent to make health-care decisions for you if you become incapable of making your own decisions. You may also name an alternate Agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you by blood or marriage, you may not appoint a person who is an operator, administrator or employee of a "facility" as defined in Chapter 111: Section 70E of the General Laws of Massachusetts's as your health care Agent if, at the time of executing the Health Care Proxy, you are a patient or resident of such facility or have applied for admission to such facility.

Your Agent may make all health-care decisions for you, including, absent a limitation by you, decisions concerning providing, withholding or withdrawing of a life sustaining procedure. Unless you limit the Agent 's authority, your Agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition unless it's a life-sustaining procedure or otherwise required by law.

(b) Select or discharge health-care providers and health-care institutions;

(c) Consent or refuse consent to life sustaining procedures, such as, but not limited to, cardiopulmonary resuscitation and orders not to resuscitate.

(d) Direct the providing, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional instructions for other than end of life decisions.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. **It is required that 2 other individuals sign as witnesses.** You should give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care and to any person(s) you name as your Health Care Agent. You should talk to the person(s) you have named as your Agent to make sure that your wishes are understood and that the person(s) is willing to take the responsibility of having your Health Care Proxy.

You may revoke a health care Agent by notifying your Health Care Agent or your health care provider orally or in writing or by any other act evidencing a specific intent to revoke the Health Care Proxy. You may replace this form at any time.

PART 1: DESIGNATION OF HEALTH CARE AGENT

(1) DESIGNATION OF AGENT: I designate the following individual as my Agent to make health-care decisions for me:

_____

(name of individual you choose as Agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke my Agent's authority or if my Agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate Agent:

_____

(name of individual you choose as first alternate Agent)

_____

(address) (city) (state) (zip code)

_____

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my Agent and first alternate Agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate Agent:

_____

(name of individual you choose as second alternate Agent)

_____

(address) (city) (state) (zip code)

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My Agent is authorized to make all health-care decisions for me, except as I state here:

(Add additional sheets if necessary.)

I. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.

A. General Grant of Power and Authority. Subject to any limitations in this Directive, my agent has the power and authority to do all of the following: (1) Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records; (2) Execute on my behalf any releases or other documents that may be required in order to obtain this information; (3) Consent to the disclosure of this information; and (4) Consent to the donation of any of my organs for medical purposes. . (If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations on the lines in section 2, Agent's Authority, above.)

B. HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually

identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My Agent's authority becomes effective when my primary physician determines I lack the capacity to make my own health-care decisions. As to decisions concerning the providing, withholding and withdrawal of life-sustaining procedures my Agent's authority becomes effective when my primary physician determines I lack the capacity to make my own health-care decisions and my primary physician and another physician determine I am in a terminal condition or permanently unconscious.

(4) AGENT'S OBLIGATION: My Agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my Agent. To the extent my wishes are unknown, my Agent shall make health-care decisions for me in accordance with what my Agent determines to be in my best interest. In determining my best interest, my Agent shall consider my personal values to the extent known to my Agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, (please check one):

☐ I nominate the Agent(s) whom I named in this form in the order designated to act as guardian.

☐ I nominate the following to be guardian in the order designated:

_____

_____

☐ I do not nominate anyone to be guardian.

PART 2: INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your Agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life

I do not want my life to be prolonged if: (please check all that apply)

☐ (i) I have a terminal condition (an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery)

and

regarding artificial nutrition and hydration, I make the following specific directions:

	I want used	I do not want used
Artificial nutrition through a conduit	☐	☐
Hydration through a conduit	☐	☐

☐ (ii) I become permanently unconscious (a medical condition that has been diagnosed in accordance with currently accepted medical standards that has lasted at least 4 weeks and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma)

and

regarding artificial nutrition and hydration, I make the following specific directions:

	I want used	I do not want used
Artificial nutrition through a conduit	☐	☐
Hydration through a conduit	☐	☐

Choice To Prolong Life

☐ I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

RELIEF FROM PAIN: Except as I state in the following space, I direct treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

(7) OTHER MEDICAL INSTRUCTIONS: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

(Add additional sheets if necessary.)

PART 3: ANATOMICAL GIFTS AT DEATH

(OPTIONAL)

(8) I am mentally competent and 18 years or more of age.

I hereby make this anatomical gift to take effect upon my death. The marks in the appropriate squares and words filled into the blanks below indicate my desires.

I give:

☐ my body;

☐ any needed organs or parts;

☐ the following organs or parts;

_____

_____

To the following person or institutions

☐ the physician in attendance at my death;

☐ the hospital in which I die;

☐ the following named physician, hospital, storage bank or other medical institution;

_____

☐ the following individual for treatment;

_____

for the following purposes:

☐ any purpose authorized by law;

☐ transplantation;

☐ therapy;

☐ research;

☐ medical education.

PART 4: PRIMARY PHYSICIAN

(OPTIONAL)

(9) I designate the following physician as my primary physician:

_____

(name of physician)

_____

(address) (city) (state) (zip code)

_____

(phone)

OPTIONAL: If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my

_____

(name of physician)

_____

(address) (city) (state) (zip code)

_____

(phone)

Primary Physician shall mean a physician designated by an individual or the individual's Agent or guardian, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

(10) EFFECT OF COPY: A copy of this form has the same effect as the original.

(11) SIGNATURE: Sign and date the form here:

I understand the purpose and effect of this document.

Date: _____

Sign Your Name: _____

Print Your Name: _____

_____

(address) (city) (state) (zip code)

(12) SIGNATURES OF WITNESSES:

Statement Of Witnesses

SIGNED AND DECLARED by the above-named declarant as and for his/her written Health Care Proxy pursuant to the General Laws of Massachusetts, Chapter 210D, who in his/her presence, at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state and affirm:

That the Principal appeared to be at least eighteen years of age, of sound mind and under no constraint or undue influence. Further, neither witness is named as a Health Care Agent in this Health Care Proxy.

First witness:

_____

(print name)

_____

(address) (city, state, zip code)

_____

(signature of witness) (date)

Second witness:

_____

(print name)

_____

(address) (city, state, zip code)

_____

(signature of witness) (date)