

DOCUMENT CONCERNING THE APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I understand that, as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and will turn to someone who knows my values and health care wishes. By signing this appointment of health care representative, I appoint a health care representative with legal authority to make health care decisions on my behalf in such case or at such time.

I appoint _____ (Name) to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment, my health care representative is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, such as for psychosurgery or shock therapy, as defined in section 17a-540, and (2) make the decision to provide, withhold or withdraw life support systems. I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in a living will, or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If this person is unwilling or unable to serve as my health care representative, I appoint _____ (Name) to be my alternative health care representative.

This request is made, after careful reflection, while I am of sound mind.

_____ (Signature)

_____ (Date)

This document was signed in our presence, by the above-named _____ (Name) who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time the document was signed.

_____ (Witness)

_____ (Address)

_____ (Witness)

_____ (Address)