

**HEALTH CARE PROXY**

I, \_\_\_\_\_, residing at \_\_\_\_\_, hereby appoint the following individual as my health care agent ("agent"):

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

to make any and all health care decisions for me which I, myself, could make in person while competent and possessed of health care decision-making capacity, except to the extent stated otherwise.

This Health Care Proxy shall take effect if and when I become unable to make my own health care decisions.

In the event the person I appoint above is unable, unwilling, or unavailable to act as my health care agent, I hereby appoint the following individual as my health care agent:

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

In respect of each health care decision made for me by my agent, it is my wish and direction that my agent be guided solely by my agent's belief as to what my own decision would have been in the same circumstances. My agent knows my desires regarding life-sustaining treatment, including but not limited to, nutrition and hydration.

*(Please check any of the following paragraphs that you wish to apply to the decisions made by your agent.)*

\_\_\_\_\_ Without limiting the unrestricted scope of my agent's authority hereunder, I expressly authorize my agent to direct that life-sustaining treatment (including, without limitation, nutrition and hydration of any kind, artificial and otherwise), be withheld or withdrawn.

\_\_\_\_\_ my agent's authority shall be subject to the limitations or specific directions detailed below:

*(State any limitations or specific directions that you wish to place on your agent's authority to make decisions for you)*

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

**HIPAA Release Authority:** I intend for my agent to be treated as I would 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 (aka HIPAA), 42 USC 1302d and 45 CFR 160-164. I authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and any 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 such information regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

The authority given my agent shall supersede any prior 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 to 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.

Dated: \_\_\_\_\_, 2006 \_\_\_\_\_

We declare that the principal who signed this document is personally known to us and appears to be of sound mind and acting willingly and free from duress. The principal signed this document in our presence. We are not the persons appointed as agent or alternate agent by this document.

\_\_\_\_\_  
WITNESS

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ADDRESS

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WITNESS

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