HEALTH CARE PROXY

Appointing Your Health Care Agent in New York State

To Our Patients:

The New York Health Care Proxy Law allows you to appoint someone you trust – for example, a family member or close friend – to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow.

To appoint a proxy, you should fill out the Health Care Proxy, on the reverse side of this form, sign it, date it, and have two witnesses sign and date it. Your agent may not be a witness.

Your agent can be any adult who is over the age of 18 or a minor who has married or is the parent of a child.

If you should ever change your mind about the wishes stated in your proxy or about the person you have designated to be your agent, you can revoke your proxy at any time to your health care providers or hospital verbally or in writing.

You can name an alternative agent when you sign your proxy, so if your agent cannot be contacted, the alternative agent can make decisions.

Talk to the person who is named as your agent, and give the agent a copy of the form. Give copies to your doctors and to any hospital or nursing home in which you are a patient. Be prepared to show them the original document. Tell family and those closest to you about the proxy and give them copies. Keep track of copies so that you can inform all these individuals if you revoke the proxy or change agents.

WGCA Physicians

New York State Health Care Proxy Form

1. I, _____ hereby appoint

_____

(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

2. Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. (Attach additional pages if necessary.)

_____
_____
_____

(Unless your agent knows your wishes about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions on reverse for samples of language you could use.)

3. Name of substitute or fill-in-agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

_____

(name, home address and telephone number)

_____

4. Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific date or conditions, if desired):

_____

5. Signature _____
Address _____
Date _____

Statement by Witnesses (must be 18 or older or see other side for exemption.)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1_____
Address _____
Witness 2_____
Address _____