Health Care Proxy
for the State of New York

(1) I, _____, hereby appoint _____ 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 only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent - If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint: _____ as my health care agent(s) to make any and all health care decisions for me, except to the extent that I state otherwise.
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint: _____ as my health care agent(s) to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.*) This proxy shall expire (*specify date or conditions*): _____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (*If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.*)

_____
_____
_____
_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), *your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.*

(5) Your Identification:

Your Name: _____
Your Address: _____
Date: _____

(6) Optional: Organ and/or Tissue Donation-I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues

_____
_____
_____
_____

☐ Limitations

_____
_____
_____
_____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

(7) Statement by Witnesses (Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)
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 No. 1
Date: _____
Name: _____
Address:

_____
_____

Witness No. 2
Date: _____
Name: _____
Address:

_____
_____

Signature

Date

Printed Name

Title/Authority

Signature

Date

Printed Name

Title/Authority

Signature

Date

Printed Name

Title/Authority