HEALTH CARE PROXY

PATIENT INFORMATION:

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____

E-mail Address: _____

I APPOINT AS MY HEALTH CARE AGENT:

Full Name: _____E-mail Address: _____

Address: _____ City: _____ State:____ Zip: _____

Home Phone: _____ Work Phone: _____

to have authority to make health care decisions on my behalf.

I APPOINT AS MY ALTERNATE HEALTH CARE AGENT:

Full Name: _____E-mail Address: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____

to have authority to make health care decisions on my behalf, when the designated Health Care Agent is not available, willing or competent to serve and is not expected to become available, willing or competent to make a timely decision given my medical circumstances, or, the designated Health Care Agent is disqualified from acting on my behalf because of other circumstances.

LIMITATIONS ON HEALTH CARE AGENT'S AUTHORITY:

The following describes the limitations, if any, that I have placed on the agent's authority:

_____

_____

_____

PATIENT'S SIGNATURE: _____ Date and Time: _____

Signed at the Direction of the Patient: _____ Date and Time: _____

WITNESSED BY:

I, *[name:]* _____, affirm that the patient appeared to be at least 18 years old, of sound mind and under no constraint or undue influence. I affirm that I am at least 18 years old and have not been named as a Health Care Agent in this Health Care Proxy.

Signature: _____ Date and Time: _____

WITNESSED BY:

I, *[name:]* _____, affirm that the patient appeared to be at least 18 years old, of sound mind and under no constraint or undue influence. I affirm that I am at least 18 years old and have not been named as a Health Care Agent in this Health Care Proxy.

Signature: _____ Date and Time: _____

Effective Date of Agent's Authority: The agent's authority shall become effective if it is determined by the attending physician, according to accepted standards of medical judgment, that I lack the capacity to make or communicate health care decisions. This determination shall be set forth in writing in my permanent medical record and shall contain the attending physician's opinion regarding the cause and nature of my incapacity as well at its extent and probable duration.

Developed pursuant to M.G.L. c. 201D Lahey
Clinic Health Care Proxy.12.20.2007

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PATIENT INFORMATION

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HEALTH CARE PROXY ADDENDUM

To My Family, Doctors, and All those Concerned with My Care:

I, _____, residing at _____

_____,
make this statement to express my wishes regarding the withholding or withdrawal of life support should a time come when, as determined by my doctor, I am unable to participate in decisions regarding my health care.

Should a time come when there is no expectation of my recovery from physical or mental disability or disease, I direct that I be allowed to die with dignity, and that my doctor withhold or withdraw treatment that merely prolongs life and is unlikely to offer a cure or remission of the disease. I direct that my treatment be limited to measures that will keep me comfortable and relieve pain.

These directions are made after careful consideration and in accordance with my strong convictions and beliefs. I expect my family, doctor, and others concerned with my care to abide by my wishes and in doing so, to be free of any legal or moral liability.

Additional Instructions/Comments:

_____

_____

_____

_____

_____

PATIENT'S SIGNATURE: _____ **Date and Time:** _____

Signed at the Direction of the Patient: _____ **Date and Time:** _____

WITNESSED BY:

I, *[name:]* _____, affirm that the patient appeared to be at least 18 years old, of sound mind and under no constraint or undue influence. I affirm that I am at least 18 years old and have not been named as a Health Care Agent in this Health Care Proxy.

Signature: _____ **Date and Time:** _____

WITNESSED BY:

I, *[name:]* _____, affirm that the patient appeared to be at least 18 years old, of sound mind and under no constraint or undue influence. I affirm that I am at least 18 years old and have not been named as a Health Care Agent in this Health Care Proxy.

Signature: _____ **Date and Time:** _____

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PATIENT INFORMATION

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