HEALTH CARE PROXY
and LIVING WILL OF

(Name Here)

I, _____, residing at _____, NY _____, hereby appoint and authorize _____, residing at _____ as my health care "proxy" to act for me in my name and to make and communicate any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect in the event that I am unable to make my own health care decisions. I direct my health-care proxy to make my health-care decisions in accordance with my wishes and any limitations as stated below, or as otherwise made known to my proxy by me.

If I should be in an incurable or irreversible mental or physical condition, with no reasonable expectation of recovery, my proxy may direct my physician to withhold and withdraw any treatment that serves to prolong my dying. My proxy knows my wishes and may direct the withdrawal of artificial nutrition and hydration. The other procedures and treatments which may be withheld and withdrawn include, without limitation, surgery, antibiotics, cardiac and pulmonary resuscitation, respiratory support, and artificially administered feeding and fluids. I direct that treatment be limited to measures to keep me comfortable and to relieve pain, even if such measures may shorten my life.

I further delegate my proxy to select, employ and discharge health-care personnel such as physicians, nurses, therapists home health-care providers and other medical professionals, and to contract in my name and on my behalf for all health care services, as my proxy deems appropriate.

I wish to live out my last days at home rather than in a hospital, if it does not jeopardize the chance of my recovery to a meaningful and conscious life and does not impose an undue burden on my family.

I further authorize my proxy to request, receive and review any information regarding my physical or mental health, including without limitation medical and hospital records; to execute on my behalf any releases or other documents that may be required in order to obtain this information or implement my health care; and to consent to the disclosure of this information. In addition to other powers granted by me in this document, my proxy shall have the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act ("HIPAA"). My proxy is authorized to execute any and all releases and other documents necessary in order to obtain disclosure of my patient records and other medical information subject to and protected under HIPAA.

In the event the health care proxy designated above is unwilling or unable to serve in that capacity, I hereby nominate _____, residing at _____, to act as my health care proxy in his/her stead..

Unless I revoke it, this health care proxy shall remain in effect indefinitely.

IN WITNESS WHEREOF, I have executed this instrument as my free and voluntary act and deed this _____ day of _____, 2020

_____
(Sign here)

WITNESS:

I declare that the person who signed this document is personally known to me and appears to be of sound mind acting of his/her own free will and the he/she signed this document in my presence.

Witness 1: Residing at:

_____ _____

_____

Witness 2: Residing at:

_____ _____

_____

Prepared by:
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