HEALTH CARE PROXY

TO: My family, physicians and all
those concerned with my care

I, **_____,** presently residing at _____, and being an adult of sound mind, hereby appoint and authorize _____, presently residing at _____, or if _____ is unable, unwilling or unavailable to act, then _____, presently residing at _____, as my agent to act for me and in my name to make and communicate any and all health care decisions for me, except to the extent that I state otherwise. This health care proxy shall take effect in the event I become unable to make my own health care decisions. I direct my agent to make health care decisions in accordance with my wishes and any limitations as stated below, or as otherwise made known to my agent. My agent does know my wishes regarding artificial nutrition and hydration.

I direct my attending physician to withhold and withdraw treatment that serves only to prolong my dying, if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to: (a) a terminal condition, (b) a permanently unconscious condition, or (c) a minimally conscious condition in which I am permanently unable to make decisions or express my wishes. The procedures and treatment to be withheld and withdrawn include, without limitation, surgery, antibiotics, cardiac and pulmonary resuscitation, respiratory support, and artificially administered nutrition and hydration. I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment. I do want maximum pain relief, even if it may hasten my death.

I further delegate to my agent the power and authority to select, employ and discharge health care personnel, such as physicians, nurses, therapists, hospice care and home health care providers, and other medical professionals; to admit or discharge me (including transfer from another facility) from any hospital, hospice, nursing home, adult home or other medical care facility; and to apply for public benefits to defray the cost of health care, and to contract in my name and on my behalf for all health care services, including without limitation medical, nursing and hospital care, as my agent may deem appropriate. I confirm that I shall be and remain personally liable for the payment of all such care and services to the same extent as if I had personally contracted therefor.

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 authorize my agent to donate all or any part of my body for transplantation, or to otherwise direct the disposition of my remains.

I authorize my agent to request, receive, obtain and review, and be granted full and unlimited access to, and consent to the disclosure of complete unredacted copies of any and all health, medical and financial information and any information or records referred to in 45 C.F.R. Sec. 164.501 and regulated by the Standards for Privacy of Individually Identifiable Health Information found in 65 Fed. Reg. 82462 as protected private records or otherwise covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I also grant authority and power to my agent to serve as personal representative for all purposes of HIPAA. I understand that the information contained in my health and medical records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) and human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol or drug abuse or addiction. I understand that I may have access to or receive an accounting of the information to be used or disclosed as provided in 45 C.F.R. Sec. 164.524 et seq. I further understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that any disclosure of this information carries with it the potential for an unauthorized further disclosure of this information by third parties and that such further disclosure may not be protected under HIPAA. In order to induce the disclosing party to disclose the aforesaid private and/or protected confidential information, I forever release and hold harmless said disclosing party who relies upon this instrument from any liability under confidentiality rules arising under HIPAA as a consequence of said disclosure. I authorize my agent to execute any and all releases or other documents that may be necessary in order to obtain disclosure of my patient records and other medical information subject to and protected by HIPAA.

I authorize my agent to execute on my behalf any documents necessary or desirable to implement the health care decisions that my agent is authorized to make pursuant to this document, including without limitation all documents pertaining to a refusal to permit medical treatment, or authorizing the leaving of a medical facility against medical advice, or any waivers or releases from liability required by a physician or health care provider.

Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition stated below. This proxy shall expire [specify date or condition, if desired]:

IN WITNESS WHEREOF, I have executed this instrument, as my free and voluntary act and deed, this ____day of _____, ____.