LIVING WILL / HEALTH CARE PROXY

I, _____, currently residing at _____, being of sound mind and memory, do make, publish and declare this my Living Will and Health Care Proxy to my family, my physicians, my lawyer and to all others whom it may concern, as follows:

FIRST: In the event that the time should come when I can no longer participate in decisions regarding my medical care, I would like this statement to stand as an expression of my firm and settled commitment to decline certain forms of medical treatment under the circumstances indicated below:

A. If I should be in a terminal condition; or

B. If I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes; or

C. If my brain is damaged to the extent that I am accurately diagnosed as being in a "permanently unconscious" and/or a "persistive vegetative state" even though a prognosis could be made that I might exist in such a state for a period longer than six (6) months; or

D. If I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, and my Health Care Proxy hereinunder designated shall decide, in my Health Care Proxy's sole discretion, that it would be in my best interest to decline medical treatment under the specific circumstances.

SECOND: Providing that any of the conditions exist as specified hereinabove under paragraph "FIRST" of this document, I hereby direct my Health Care Proxy to make health care decisions on my behalf in accordance with my wishes as stated within this Living Will and Health Care Proxy and with regard for the following specific provisions, which are intended to specifically document my wishes with regard to the following circumstances and are not intended as a limitation on the absolute discretion of my Health Care Proxy hereinunder designated to refuse additional treatments or procedures:

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A. I direct that I not be given any medical treatments, interventions or procedures that only serve to prolong the process of dying. I further direct my attending physician to withdraw any such treatment that may have been previously commenced. Included in these medical procedures, treatments and interventions are, by way of example and not by way of limitation, such things as cardiopulmonary resuscitation, transplantation, amputation, artificial respiration, and artificial hydration or artificial nutrition delivered by naso-gastric or other methods.

B. I direct that no cardiopulmonary resuscitation that requires invasion of my body by surgical means shall be administered to me if I should sustain cardiac or pulmonary arrest.

C. I consent to the entry in my medical records of a do not resuscitate order as that term is defined in Section 2960-78 of Article 29B of the New York Public Health Law.

D. If I should have any of the terminal and/or other serious conditions described or alluded to herein, and I am unable to use my own body muscles and gag reflex to swallow and digest food in a normal fashion, I do not wish to be fed by artificial means, such as intravenously or by the insertion of tubes into any other part of my body.

THIRD: I direct that medical 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 further request that medications be mercifully administered to me to alleviate suffering, even if such medications might shorten my remaining life span.

FOURTH: I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (a/k/a HIPAA), 42 USC 1320d and 45 CFR 160-164.

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I authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illnesses and drug or alcohol abuse.

The authority given my agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

FIFTH: I hereby appoint _____, currently residing at _____, 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.

SIXTH: In the event _____, is unable, unwilling or unavailable to act as my health care agent, I nominate and appoint _____, currently residing at _____, to serve as substitute proxy.

SEVENTH: If any of my tissues or organs are sound and would be of value as transplants to help other people, I freely give my permission for such donation.

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EIGHTH: These directions express my legal right to refuse treatment under the laws of the State of New York. It is my intention and desire that the wishes and directions which are expressed in this statement shall be carried out to the extent permitted by law, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Signature: _____
Name:

Address:

Date:

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STATEMENT BY WITNESSES:
(must be 18 years of age or older)

We declare that the person who signed this document is personally known to us and appears to be of sound mind and acting of their own free will and without duress. Said person signed this document in our presence, and we are not the person appointed as agent by this document.

Witness #1: _____
Name:

Address:

Phone:

Date:

Witness #2: _____
Name:

Address:

Phone:

Date:

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