HEALTH CARE PROXY

(1) I, ____________________________, hereby appoint ___________________________________, residing at _______________________________________, Telephone Number _____________, 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:** If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____________________, residing at ______________________________, Telephone Number ________________, as my health care agent 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 instruction, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions:

____

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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.

(5) My agent 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 agent is authorized to execute any authorization forms required to release my patient records and other medical information subject to and protected under HIPAA.

(6) **Your Identification**

Your Name: ____

Your Signature: ____ Date: _____________, 2020

Your Address: ____

* Executing this health care proxy form does not in any way take the place of legal advice from Littman Krooks LLP or a qualified elder law attorney. This health care proxy form does not in any way take the place of a estate plan, and addresses only one element of incapacity planning. This health care proxy form does not constitute legal advice, and does not create an attorney client relationship between yourself and Littman Krooks LLP.

(7) **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 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.

Your Signature: ______________________________________ Date: _____________, 2020

8) **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/her own free will. He/She signed *(or asked another to sign for her/him)* this document in my presence.

Witness 1	**Witness 2**
Date: __________, 2020	Date: __________, 2020
(Print) __________________________	*(Print)* __________________________
Signature _______________________	Signature _______________________
Address _________________________	Address _________________________
_______________________________	_______________________________

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