Health Care Proxy

(Durable Power of Attorney for Health Care)

I, _____ (Your Name), currently of _____ (Your Street Address), _____ (Your Town), _____ (Your State) as Principal, hereby appoint _____ (Agent's Name), currently of _____ (Agent's Street Address), _____ (Agent's Town), _____ (Agent's State) to be my Health Care Agent pursuant to Chapter 201D of the Massachusetts General Laws with authority to make all health care decisions on my behalf, without limitation, if my attending physician determines that I lack capacity to make or communicate health care decisions. If my designated Agent is not (and is not likely to become) available, willing or competent to make a timely decision on my behalf, then I appoint _____ (Successor Agent's Name), currently of _____ (Successor Agent's Street Address), _____ (Successor Agent's Town), _____ (Successor Agent's State) to serve in _____ (Agent's Name)'s place. I hereby revoke any previous Health Care Proxy which I may have executed heretofore.

My agent is intended to be my personal representative for HIPPA (the Health Insurance Portability and Accountability Act of 1996) purposes. My agent shall have the authority to make all health care decisions for me, including decisions about life sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them EXCEPT (here list the limitations, <u>if any</u>, you wish to place on your Agent's authority):

I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's personal assessment of my best interests.

The following declaration is for the guidance of my Health Care Agent and any others who may require guidance (and not for the purposes of limiting the authority of my Health Care Agent): If at any time I should be diagnosed in writing to be in a terminal condition or in a permanent unconscious condition by the attending physician, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally.

In the event of any conflict between this health care proxy and the decision of my Agent or between any declaration or living will I have made or may make and the decision of my Agent, the good faith decision of my Agent shall govern. Decisions of my Agent pursuant to this health care proxy shall have the same priority over decisions by any other person, including my attorney-in-fact, if any, as if I had made the decision myself.

My Health Care Agent's authority to act on my behalf shall exist only for the period during which my attending physician determines that I lack capacity to make or communicate health care decisions for myself.

My Agent shall be indemnified and held harmless by me or my estate for any liability for the cost

of health care incurred by my Agent pursuant to this health care proxy. I intend that the decisions of my Agent be honored by my family, my attending physician and other health care providers and I hereby release them and agree to indemnify and hold them harmless from any and all liability for acting in accordance with such decisions. If this health care proxy is revoked, my Agent shall be indemnified and held harmless by me or my estate for health care decisions and the cost of health care made or incurred by my Agent before receiving actual notice of such revocation.

Nothing in this Health Care Proxy shall preclude any medical procedures which my attending physician determines necessary to provide for my comfort or pain alleviation.

Photocopies of this Health Care Proxy shall have the same force and effect as the original.

In Witness Whereof, I hereby declare that I sign and execute this instrument as my Health Care Proxy, that I sign it willingly in the presence of each of the undersigned witnesses, neither of whom is my Health Care Agent or Alternate, and that I execute it as my free and voluntary act for the purposes herein expressed.

Date:_____ _____

(Your Signature)

We, the undersigned witnesses, each do hereby declare in the presence of the aforesaid _____
(Your Name)
that he/she signed and executed this instrument as his/her Health Care Proxy in the presence of each of us, that he/she signed it willingly, that each of us hereby signs this instrument as witness in the presence of

_____and that to the best of our knowledge he/she is eighteen (18) years of age or over,
(Your Name)
of sound mind, and under no constraint or undue influence.

_____ residing at _____

_____ residing at _____
Witness

I, _____, hereby accept my appointment as Health Care Agent.
(Agent's Name)

_____
(Agent's Signature)