



Date of Birth ____/____/____

Baystate  Health
Massachusetts Health Care Proxy

1. I, _____ Address: _____,

appoint the following person to be my Health Care Agent with the authority to make health care decisions on my behalf. This authority becomes effective if my attending physician determines in writing that I lack the capacity to make or communicate health care decisions myself, according to Chapter 201D of the General Laws of Massachusetts.

2. My Health Care Agent is:

Name: _____ Address: _____

Phone(s): _____; _____; _____

3. My Alternate Health Care Agent

If my Agent is not available, willing or competent, or not expected to make a timely decision, I appoint:

Name: _____ Address: _____

Phone(s): _____; _____; _____

4. My Health Care Agent's Authority

I give my Health Care Agent the same authority I have to make any and all health care decisions including life-sustaining treatment decisions, except (list limits to authority or give instructions, if any):

I authorize my Health Care Agent to make health care decisions based on his or her assessment of my choices, values and beliefs if known, and in my best interest if not known. I give my Health Care Agent the same rights I have to the use and disclosure of my health information and medical records as governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d. Photocopies of this Health Care Proxy have the same force and effect as the original.

5. Signature and Date. I sign my name and date this Health Care Proxy in the presence of two witnesses.

SIGNED _____ **DATE** _____

6. Witness Statement and Signature

We, the undersigned, have witnessed the signing of this document by or at the direction of the signatory above and state the signatory appears to be at least 18 years old, of sound mind and under no constraint or undue influence. Neither of us is the health care agent or alternate agent.

Witness One

Signed: _____

Print Name: _____

Date: _____

Witness Two

Signed: _____

Print Name: _____

Date: _____

7. Health Care Agent Statement (Optional):

We have read this document carefully and accept the appointment.

Health Care Agent _____ Date _____

Alternate Health Care Agent _____ Date _____

Massachusetts Health Care Proxy Instructions and Document

Instructions: Every competent adult, 18 years old and older, has the right to appoint a Health Care Agent in a Health Care Proxy. To create your Health Care Proxy, print this two page form and place the instructions page and the blank document in front of you. Follow the step-by-step instructions and sign and date the Health Care Proxy in front of two witnesses, who sign and date the document after you.

1. Your Name and Address *(Required)*

Print your full name in the blank space. Print your address.

2. My Health Care Agent is: *(Required)*

Print the name, address and phone numbers of your Health Care Agent.

- Choose a person you trust to make health care decisions for you based on your choices, values and beliefs, if you cannot make or communicate decisions yourself;
- Your Health Care Agent and Alternate Agent cannot be a person who is an operator, administrator or employee in the facility where you are a patient or resident or have applied for admission, unless they are related to you by blood, marriage or adoption.

3. My Alternate Health Care Agent *(Not required, but helpful to have an Alternate Agent)*

If possible, appoint a person you trust as a back-up or Alternate Agent, who can step-in to make health care decisions if your Health Care Agent is not available, not willing or not competent to serve, or is not expected to make a timely decision. Print the name, address and phone numbers.

4. My Health Care Agent's Authority *(Required)*

Here's where you give your Agent either the broadest possible decision-making authority to make "any and all" decisions including life sustaining treatments, or limit his/her authority:

- If you want to give "any and all" decision-making authority, just leave this area blank.
- If you do not want to give "any and all" decision-making authority, describe the way in which you want to limit your Agent's authority and write it down in the space provided.

5. Signature and Date *(Required)*

Do NOT sign ahead. Sign your full name & date in front of two adult witnesses who sign after you.

- You can have someone sign your name at your direction in front of two witnesses.

6. Witness Statement and Signature *(Required)*

Any competent adult can be a witness except your Health Care Agent and Alternate Agent.

- Two adults must be present as witnesses when this document is signed. They watch as you sign the document, or as another person signs at your direction, and sign after you to state that you are at least 18 years old, of sound mind, and under no constraint or undue influence.
- Have Witness One sign, then print his or her name and the date;
- Then have Witness Two sign and print his or her name and the date.

7. Health Care Agent Statement *(Optional)*

This section is not required, but it can help your doctors and family know the Agents you appointed have accepted the position. Your Agent(s) signs and prints the date in the spaces provided.

Important: Keep your original Health Care Proxy. Make a copy and give it to your Health Care Agent. Give a copy to your doctors and care providers to scan in your medical record so they know how to contact your Agent if you are ill or injured and unable to speak for yourself.