# HEALTH CARE PROXY

## -of-

## #YOUR NAME HERE#

I, **#NAME#,** presently residing at _____, being of sound mind and body, hereby appoint my _____, **#AGENT#**, presently residing at _____ (Telephone No.: ) as my health care agent and proxy 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.

I hereby revoke all prior Health Care Proxies that I have given.

I direct my proxy to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows:

> I expressly authorize my Agent(s) to direct that life sustaining treatment, including, without limitation, nutrition and hydration of any kind, artificial or otherwise, mechanical respiration (including intubation), be administered, withheld or withdrawn, as we have thoroughly discussed these issues and my agent is fully acquainted with my wishes. Also, I want to live out my days at home rather than in a hospital or nursing home if it does not jeopardize the chance of my recovery to a meaningful and conscious life.

If the health care agent and proxy I appoint above is unable, unwilling or unavailable to act as my health care agent, I nominate and appoint my _____, **#AGENT2#,** presently residing at _____ (Telephone No.: ).

HIPAA RELEASE AUTHORITY I intend for my agent, hereby designated as my personal representative under HIPAA pursuant to 45 CFR 164.502(g)(2), 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 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164. 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 who has provided treatment or services to me or who has paid for or is seeking payment from me for such services to give, disclose and release to my agent and personal representative, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition.

The authority given my agent and personal representative 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 and personal representative 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.

Unless I revoke it, this proxy shall remain in effect indefinitely.

**Signature:** _____ **Date:** _____
**#NAME#**

Statement by Witnesses:

I declare that the person who signed this document is personally known to me and appears to be of sound mind and memory and acting of his or her own free will. He or she signed this document in my presence and in the presence of the other witness.

**Witness** _____ **Address** _____

_____

**Witness** _____ **Address** _____

_____

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# OF

## #YOUR NAME#

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