

MASSACHUSETTS HEALTH CARE PROXY

TO MY FAMILY, DOCTORS, AND ALL THOSE CONCERNED WITH MY CARE

1. Appointment

I, _____, residing at _____, Massachusetts, being a competent adult at least eighteen years of age or older, of sound mind and under no constraint or undue influence, hereby appoint the following person to be my **HEALTH CARE AGENT** under the terms of this document:

Name: _____

Address: _____

Telephone: _____

In doing so, I intend to create a Health Care Proxy according to Chapter 201D of the General Laws of Massachusetts. In making this appointment, I am giving my Health Care Agent the authority to make any and all health care decisions on my behalf in the event that I should at some future time become incapable of making health care decisions for myself.

2. Alternate Appointment

In the event that my original Health Care Agent is not available, willing or competent to serve and is not expected to become available, willing or competent to make a timely decision given my medical circumstances, then I appoint the following person to be my Health Care Agent:

Name: _____

Address: _____

Telephone: _____

3. Powers Given to Health Care Agent

- A. I give my Health Care Agent full authority to make any and all health care decisions for me including decisions about life-sustaining treatment.

- B. My Health Care Agent shall have authority to act on my behalf only if, when and for so long as a determination has been made that I lack the capacity to make or to communicate health care decisions for myself. This determination shall be made in writing by my

attending physician according to accepted standards of medical judgment and the requirements of Chapter 201D of the General Laws of Massachusetts.

- C. The Authority of my Health Care Agent shall cease if my attending physician determines that I have regained capacity. The authority of my Health Care Agent shall recommence if I subsequently lose capacity and consent for treatment is required.
- D. I shall be notified of any determination that I lack capacity to make or communicate health care decisions where there is any indication that I am able to comprehend such notice.
- E. My Health Care Agent shall make health care decisions for me only after consultation with my health care providers and after full consideration of acceptable medical alternatives regarding diagnosis, prognosis, treatments and their side effects.
- F. My Health Care Agent shall make health care decisions for me only in accordance with my Health Care Agent's assessment of my wishes, including my religious and moral beliefs, or, if my wishes are unknown, in accordance with my Health Care Agent's assessment of my best interests.
- G. My Health Care Agent shall have the right to receive any and all medical information necessary to make informed decisions regarding my health care, including any and all confidential medical information that I would be entitled to receive.
- H. The decisions made by my Health Care Agent on my behalf shall have the same priority as my decisions would have if I were competent over decisions by any other person, including a person acting pursuant to a durable power of attorney, except for any specific Court Order overriding this Health Care Proxy.
- I. If I object to a health care decision made by my Health Care Agent, my decision shall prevail unless it is determined by Court Order that I lack capacity to make health care decisions.
- J. Nothing in this proxy shall preclude any medical procedure deemed necessary by my attending physician to provide comfort care or pain alleviation including but not limited to treatment with sedatives, and painkilling drugs, non-artificial oral feeding, suction and hygienic care.

4. Revocation

This Health Care Proxy shall be revoked upon either one of the following events:

- A. My execution of a subsequent Health Care Proxy;
- B. My notification to my Health Care Agent or a health care provider orally or in writing or by other act evidencing a specific intent to revoke the Health Care Proxy.

5. Statement of Principal

In order to provide my Health Care Agent with a more detailed indication of my wishes, but without in any way limiting the full and absolute authority granted above, I hereby declare that I would specifically refuse the following measures of artificial life support:

- A. Electrical or mechanical resuscitation of my heart when it has stopped beating;
- B. Nasogastric tube feeding when I am paralyzed or unable to take nourishment by mouth;
- C. Mechanical respiration when I am no longer able to sustain my own breathing;
- D. Other extraordinary medical or surgical procedures, artificial means or interventions to sustain or prolong biological function.

6. Statement of Health Care Agent

I have read this document carefully and accept the appointment.

7. Signature of Principal

I hereby sign my name on this date, _____, 2005, to this Health Care Proxy in the presence of two witnesses.

8. Acknowledgment

COMMONWEALTH OF _____
COUNTY OF _____

On this _____ day of _____, 2005, before me, the undersigned notary public, personally appeared _____, proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding or attached document, and acknowledged to me that he signed it voluntarily for its stated purpose.

Notary Public
My Commission Expires:

9. Witnesses

Witness 1

I, the undersigned, have witnessed the signing of this document by the principal and state that the principal appears to be at least eighteen years of age, of sound mind and under no constraint or undue influence. I have not been named as Health Care Agent or alternate Health Care Agent in this document.

Signature: _____
Name (print): _____
Address: _____

Date: _____

Witness 2

I, the undersigned, have witnessed the signing of this document by the principal and state that the principal appears to be at least eighteen years of age, of sound mind and under no constraint or undue influence. I have not been named as Health Care Agent or alternate Health Care Agent in this document.

Signature: _____
Name (print): _____
Address: _____

Date: _____