Health Care Proxy Form

Address

DESIGNATION OF HEALTH CARE AGENT:

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My healthcare agent has the authority to make any and all healthcare decisions on my behalf, including, but not limited to, decisions regarding medical treatment, surgery, hospitalization, and medication. This authority includes the power to consent, refuse consent, or withdraw consent to any medical treatment, as well as the power to make decisions about organ donation, autopsy, and the disposition of my remains.

GUIDANCE FOR HEALTH CARE AGENT:

GUIDANCE FOR HEALTH CARE AGENT: I provide the following guidance to my healthcare agent regarding my preferences for medical treatment and end-of-life care:

This healthcare proxy will remain in effect unless and until I revoke it. I reserve the right to revoke this health care proxy at any time by notifying my health care agent or my attending physician in writing.

This healthcare proxy becomes effective when my attending physician determines that I am unable to make my own healthcare decisions. My attending physician will document this determination in my medical records.

I authorize any physician, health care professional, or health care facility to disclose to my health care agent any information regarding my physical or mental health, medical history, or medical treatment.

Signature
Date: _____ dd / mm / yyyy

WITNESS:

WITNESS: