Massachusetts Health Care Proxy

1. APPOINTMENT OF HEALTH CARE AGENT AND ALTERNATE

I, of

Date of Birth:

the "Principal," hereby appoint of

as my Health Care Agent ("Agent") to make health care decisions for me as authorized in this Health Care Proxy and under Chapter 201D of the General Laws of Massachusetts, including any future amendments ("Chapter 201D"). Capitalized terms used and not defined in this Health Care Proxy have the meaning specified in Chapter 201D.

If for any reason my Agent named above is not able or willing to act as my Agent and is not expected to become able or willing to make a timely decision given my medical circumstances,

then I hereby appoint

of
as my Agent

2. AGENT'S AUTHORITY TO ACT

My Agent is authorized to act on my behalf only if my Attending Physician determines, as provided in Section 6 of Chapter 201D, that I lack Capacity to Make Health Care Decisions or to communicate my decisions. Notice that such a determination has been made must be given orally and in writing (a) to me, if there is any indication that I could comprehend the notice, (b) to my Agent and (c) if I am in or transferred from a mental health Facility, to the director of the Facility.

My Agent's authority will end if my Attending Physician determines that I have regained Capacity to Make Health Care Decisions and will resume if it is again determined that I lack such capacity.

Notwithstanding a determination that I lack Capacity to Make Health Care Decisions, if I object to any decision made by my Agent, my decision will prevail unless a court of competent jurisdiction determines that I lack Capacity to Make Health Care Decisions.

3. AGENT'S POWERS

My Agent has complete authority to make any Health Care decisions for me, including decisions about life-sustaining treatment. My Agent should make Health Care decisions for me (a) only after consultation with my Health Care Providers and consideration of all acceptable medical alternatives regarding diagnosis, prognosis, treatments and their side effects, and (b) according to my Agent's assessment of my wishes as known to my Agent, including my religious and moral beliefs or, if my wishes are not known, according to what my Agent determines to be in my best interest.

I authorize my Agent:

(a) to act as my **Personal Representative**, to receive any and all medical information regarding me or my Health Care, including any protected health information that I would be entitled to receive, and to disclose the information to others;
(b) to employ and discharge Health Care Providers and related support personnel;

Massachusetts Health Care Proxy

(c) to arrange my admission to or discharge from any Facility, even if against medical advice;
(d) to contract for any Health Care for me at my expense, without incurring personal liability for the payment of any Health Care;
(e) to authorize the withholding or the stopping of any medical treatment including artificial or mechanical nutrition and hydration;
(f) to authorize or consent to the issuance of a Do Not Resuscitate (DNR) order, and,
(g) to do all things necessary to carry out the intent of this Health Care Proxy, including granting any waiver or release from liability required by a Health Care Provider, signing documents relating to a refusal of treatment and pursuing any legal action in my name and at my expense to ensure compliance with my wishes as determined by my Agent.

4. REVOCATION

This Health Care Proxy will be revoked if:

(a) I sign a subsequent Massachusetts Health Care Proxy; or
(b) I notify my Agent or one of my Health Care Providers orally or in writing or by any other act showing a specific intent to revoke this Health Care Proxy.

5. PROXY VALIDITY AND PHOTOCOPIES

This document shall be presumed to be valid unless actual proof is offered of a new Health Care Proxy, or that other revocation has occurred.

Photo-copies of this Proxy shall be valid and have the same effect as an original document.

By signing this Health Care Proxy, I declare that I understand its contents and the effect of this grant of authority to my Agent. I further state that I sign this document willingly in the presence of each of the undersigned witnesses, and that I sign it as my voluntary act for the purposes expressed, on this day,

Sign Here: _____

We, the witnesses who sign below, each declare in the presence of the Principal that neither of us has been named as Agent or alternate Agent in this Health Care Proxy. We further declare that the Principal signed this instrument as a Health Care Proxy in the presence of each of us, that the Principal signed it willingly, that each of us signs this Health Care Proxy as witness in the presence of the Principal and that to the best of our knowledge the Principal is eighteen (18) years of age or over, of sound mind, and under no constraint or undue influence.

_____	_____
Witness's Signature	Witness's Signature
_____	_____
Print Witness's Name	Print Witness's Name