# Health Care Proxy Form

Address

I, Your name , residing at
Residential address hereby appoint
Healthcare agent, residing at
Residential address , as my health care agent to make health care decisions for me in the event that I am unable to do so.

**DESIGNATION OF HEALTH CARE AGENT:**

I designate Health care agent as my health care agent. If
Health care agent is unable or unwilling to act as my health care agent, I designate Alternative health care agent, residing at
Residential address as my alternate health care agent.

**AUTHORITY OF HEALTH CARE AGENT:**

My health care 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:**

I provide the following guidance to my health care agent regarding my preferences for medical treatment and end-of-life care:

Preferences

**DURATION OF AUTHORITY:**

This health care 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.

**EFFECTIVENESS:**

This health care 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.

**RELEASE OF INFORMATION:**

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.

IN WITNESS WHEREOF, I have executed this Health Care Proxy Form on Date_____.

_____ _____

Signature Date

**WITNESS:**

I, the undersigned, declare that the principal, [Your Full Name], has signed this Health Care Proxy Form in my presence, and I believe them to be of sound mind and under no duress.

Witness 1: Name of Witness_____ Date: Date_____

Witness 2: Name of Witness_____ Date: Date_____