

1 **Disclaimer**

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3 *Please read before preparing any documents of this importance without benefit of an*
4 *attorney.*
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6 The law office of BRAD S. MARGOLIS has provided the forms for those of you
7 who can not afford an attorney. Be very careful before you attempt to do your
8 own Living will or Health care proxy consult a qualified attorney regarding all
9 your options While we try to make sure that the information provided is current,
10 complete and accurate, laws can change quickly. You should always formally
11 engage a lawyer of your choosing before taking actions which have legal
12 consequences.
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15 BRAD S. MARGOLIS,ESQ.
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1 **NOTICE AND WARNING TO PERSON EXECUTING THIS**
2 **DOCUMENT --**

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4 **THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE EXECUTING THIS**
5 **DOCUMENT YOU SHOULD KNOW THESE IMPORTANT FACTS:**
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9 EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS
10 DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT THE
11 POWER TO MAKE HEALTH CARE DECISIONS FOR YOU WHEN YOU ARE NO
12 LONGER CAPABLE OF MAKING HEALTH CARE DECISIONS FOR YOURSELF.
13 YOUR AGENT MUST ACT CONSISTENTLY WITH YOUR DESIRES AS STATED
14 IN THIS DOCUMENT OR OTHERWISE MADE KNOWN. UNLESS YOU STATE
15 OTHERWISE, YOUR AGENT HAS THE SAME AUTHORITY TO MAKE
16 DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE HAD.
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22 YOUR AGENT HAS THE POWER TO MAKE A BROAD RANGE OF HEALTH
23 CARE DECISIONS FOR YOU. THE PERSON YOU APPOINT AS YOUR AGENT
24 SHOULD BE SOMEONE YOU KNOW AND TRUST. YOU SHOULD DISCUSS
25 THIS DOCUMENT WITH YOUR AGENT.
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30 EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS
DOCUMENT GIVES YOUR AGENT THE POWER TO CONSENT TO YOUR
PHYSICIAN NOT GIVING TREATMENT OR STOPPING TREATMENT
NECESSARY TO KEEP YOU ALIVE.

NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE
MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG
AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE
PARTICULAR DECISION. NO TREATMENT MAY BE GIVEN TO YOU OVER
YOUR OBJECTION AT THE TIME, AND HEALTH CARE NECESSARY TO KEEP
YOU ALIVE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT AT THE
TIME.

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THIS DOCUMENT GIVES YOUR AGENT AUTHORITY TO CONSENT, TO REFUSE TO CONSENT, OR TO WITHDRAW CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. THIS POWER IS SUBJECT TO ANY STATEMENT OF YOUR DESIRES AND ANY LIMITATIONS THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY SPECIFY IN THIS DOCUMENT ANY TYPES OF TREATMENT THAT YOU DO OR DO NOT DESIRE.

IN ADDITION, A COURT CAN TAKE AWAY THE POWER OF YOUR AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOUR AGENT AUTHORIZES ANYTHING THAT IS ILLEGAL, OR ACTS CONTRARY TO YOUR KNOWN DESIRES AS STATED IN THIS DOCUMENT.

YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY OF YOUR AGENT OR TO REVOKE THIS DOCUMENT ENTIRELY BY NOTIFYING YOUR AGENT OR YOUR ATTENDING PHYSICIAN, HOSPITAL, OR OTHER HEALTH CARE PROVIDER ORALLY OR IN WRITING OF THE REVOCATION.

UNLESS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER AFTER YOU DIE TO DONATE YOUR BODY OR PARTS THEREOF FOR TRANSPLANT OR THERAPEUTIC, EDUCATIONAL OR SCIENTIFIC PURPOSES, AND TO DIRECT THE DISPOSITION OF YOUR REMAINS.

IT IS IMPORTANT THAT YOU UNDERSTAND THE NATURE AND RANGE OF DECISIONS THAT MAY BE MADE ON YOUR BEHALF. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK YOUR ATTORNEY OR PHYSICIAN TO EXPLAIN IT TO YOU. YOU SHOULD DISCUSS THIS DOCUMENT WITH YOUR AGENT.

1 YOUR AGENT MAY NEED THIS DOCUMENT IMMEDIATELY IN CASE OF AN
2 EMERGENCY THAT REQUIRES A DECISION CONCERNING YOUR HEALTH
3 CARE. EITHER KEEP THIS DOCUMENT WHERE IT IS IMMEDIATELY
4 AVAILABLE TO YOUR AGENT AND ALTERNATE AGENT OR GIVE EACH OF
5 THEM AN EXECUTED COPY OF THIS DOCUMENT. YOU ALSO MAY WANT TO
6 GIVE YOUR PHYSICIAN AN EXECUTED COPY OF THIS DOCUMENT.
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HEALTH CARE PROXY

TO: My family, physicians and all those concerned with my care

I, _____, presently residing
at _____, _____, New York _____, and being an adult of
sound mind, hereby appoint and authorize _____
, presently residing at _____, _____, _____ tel. no.: (____) _____ -
_____, as my agent to act for me and in my name to make and communicate any
and all health care decisions for me, except to the extent that I state otherwise.

This proxy shall take effect in the event I become unable to make my own health
care decisions. I direct my agent to make health care decisions in accordance
with my wishes and any limitations as stated below, or as otherwise made known
to my agent.

If I should be in an incurable or irreversible mental or physical
condition with no reasonable expectation of recovery, I direct my attending
physician to withhold and withdraw treatment that serves only to prolong my
dying. These directions shall apply if (a) I am in a terminal condition, (b) I am
permanently unconscious, or (c) I am conscious but have irreversible brain damage
and will never regain the ability to make decisions and express my wishes. The
procedures and treatment to be withheld and withdrawn include, without limitation,
surgery, antibiotics, cardiac and pulmonary resuscitation, respiratory support, and
artificially administered feeding and fluids. I direct that treatment be limited to
measures to keep me comfortable and to relieve pain, even if such measures
shorten my life.

I further delegate to my agent the power and authority to select,
employ and discharge health care personnel, such as physicians, nurses,
therapists, home health care providers and other medical professionals, and to
contract in my name and on my behalf for all health care services, including
without limitation medical, nursing and hospital care, as my agent may deem
appropriate. I confirm that I shall be and remain personally liable for the payment
of all such care and services to the same extent as if I had personally contracted
therefore.

I authorize my agent to donate all or any part of my body for
transplantation, therapy, advancement of medical or dental science, research, or
other medical, educational or scientific purpose, or to otherwise direct the
disposition of my remains.

I further authorize my agent to request, receive and review any
information regarding my physical or mental health, including without limitation
medical and hospital records; to execute on my behalf any releases or other
documents that may be required in order to obtain this information; and to consent

1 to the disclosure of this information. I authorize my agent to execute on my
2 behalf any documents necessary or desirable to implement the health care
3 decisions that my agent is authorized to make pursuant to this document,
4 including without limitation all documents pertaining to a refusal to permit
5 medical treatment, or authorizing the leaving of a medical facility against medical
6 advice, or any waivers or releases from liability required by a physician or health
7 care provider.
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9 Unless I revoke it, this proxy shall remain in effect indefinitely, or
10 until the date or condition stated below. This proxy shall expire [specify date or
11 condition, if desired]:
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14 **IN WITNESS WHEREOF**, I have executed this instrument, as my free
15 and voluntary act and deed, this _____ day of _____, 200__.

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17 _____
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19 WITNESS:

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21 We, _____ and _____ each hereby
22 attest and declare under penalty of perjury under the laws of New York that: (1) the
23 foregoing instrument was personally signed by _____ in my presence, and thereupon I, at his
24 request and in his presence and in the presence of the other witnesses, have hereunto
25 subscribed my name as a witness; (2) I did not sign the above signature of _____ for or at his
26 direction; (3) I personally know _____ and believe him to be of sound mind and under no
27 constraint, duress, fraud or undue influence; (4) I am not related to _____ by blood, marriage or
28 adoption; (5) I am not entitled (to the best of my knowledge and belief) to any portion of
29 the estate of _____ upon his death under any will or codicil of _____ or by operation of law; (6) I do
30 not have any present or inchoate claim against any portion of the estate of _____; (7) I do not
have any financial responsibility for the medical care of _____; (8) I am not a physician or an
employee of any physician, and I am not an operator or employee of, or patient in, any
hospital, health care provider, residential care facility, community care facility or similar
institution; (9) I am not a person named as agent in this instrument; and (10) I and _____ are
both at least 18 years of age.

Dated: _____, 200__

Residing at

Residing at

