

HEALTH CARE PROXY

To My Family, Doctors and All Those Concerned With My Care

I APPOINTMENT

I, XXX XXX (the Principal), of XXX, Middlesex County, 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 as my Health Care Agent under the terms of this document:

Name: XXX XXX

Address:

Telephone:

In doing so, I intend to create a Health Care Proxy according to Chapter 201D of the Massachusetts General Laws. In making this appointment, I am giving my Health Care Agent the authority to make any and all decisions on my behalf, subject to any limitations I state here in this document, in the event that I should at some future time become incapable of making health care decisions myself. In addition, I intend that my wishes expressed in this instrument with respect to the nature of those decisions be given full force and effect in any other state or country in which I find myself.

II ALTERNATE APPOINTMENT

I hereby appoint the following person to serve as my Health Care Agent 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, or in the event that my original Health Care Agent is disqualified from acting on my behalf.

Name: XXX

Address:

Telephone:

I hereby appoint the following person to serve as my Health Care Agent in the event that my alternate 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, or in the event that my original Health Care Agent is disqualified from acting on my behalf.

Name: XXX

Address:

Telephone:

III HIPAA RELEASE AUTHORITY

I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. The release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (A.K.A. HIPAA), 42 USC 1320d and 45 CFR 160-164.

I authorize:

- any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau Inc. or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services;
- to give, disclose and release to my agent, without restriction;
- all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

The authority given my agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

IV POWERS GIVEN TO HEALTH CARE AGENT

My Health Care Agent's authority to make health care decisions on my behalf shall become effective once a determination is made, pursuant to the provisions of Section 6 of Chapter 201D, that I lack the capacity to make or to communicate health care decisions on my behalf.

- 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, subject only to the limitations stated below.
- 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 communicate health care decisions for myself. This determination shall be made in writing by my attending physician according to the accepted standards of medical judgment and the requirements of Chapter 201D of the Massachusetts General Laws.
 - a To receive any medical information regarding me or my Health Care, including any confidential medical information that I would be entitled to receive, and to disclose the information to others;
 - b To arrange my admission to or discharge from any Facility, even if against medical advice;
 - c To contract and make all necessary arrangements for me at any hospital, hospice, nursing home, convalescent home, or similar establishment and to assure all my needs are provided for at such facility, and to bind me to pay for all such services and facilities. To provide for companionship for me as will meet my needs and preferences at a time when I am disabled or otherwise unable to arrange for such companionship myself;

- 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 employ and discharge Health Care Providers and related support personnel;
- C. To make anatomical gifts that will take effect at my death, if I have indicated a wish to do so, or my agent believes it would be my wish to do so, to such persons and organizations as my agent shall deem appropriate and to execute such papers and do such acts as shall be necessary, appropriate, incidental, or convenient in connection with such gifts;
- D. To make advance arrangements for and be reimbursed for my funeral and burial or cremation or other last resting place, and other such arrangements that my agent deems appropriate, taking into consideration any wishes I may have made regarding this matter;
- E. 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 any documents relating to a refusal of treatment and pursuing any legal action in my name and at my expense to force compliance with my wishes as determined by my Agent;
- F. To resort to the courts on my behalf and at my expense for the following but not limited to:
 - a A declaratory judgment from any court of competent jurisdiction interpreting the validity of any and all acts authorized by this instrument, but such a declaratory judgment shall not be necessary in order for my agent to perform any acts authorized by this instrument;
 - b An injunction, or any other court order requiring compliance with my Agent's instructions by any person, organization, corporation, or other entity obliged to comply with instructions given by me;
 - c To recover any and all damages, including punitive, against any person, organization, corporation, or other entity obligated to comply with the instructions given by me or my agent who negligently or willfully fails or refuses to follow such instructions;
- G. To sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient, or proper in order to exercise any of the powers described on this document and to incur reasonable costs on my behalf in the exercise of any such powers; and
- H. To be reimbursed by me or by my personal representative for expenses reasonably incurred while acting as my Agent and acting in good faith hereunder, provided the Agent's best efforts have been used to provide receipts for such costs.
- I. 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.
- J. 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 this notice.
- K. My Health Care Agent shall make health care decisions for me only after consultations with my health care providers and after full consideration of acceptable medical alternatives regarding diagnosis, prognosis, treatments, and their side affects.

- L. My Health Care Agent shall make health care decisions for me in accordance with my Health Care Agent's assessment of my wishes, including my religious and moral beliefs, or, if my beliefs are unknown, in accordance with my Health Care Agent's assessment of my best interests.
- M. 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.
- N. 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 limitation I state below or a specific Court Order overriding this Health Care Proxy.
- O. 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 sedative and painkilling drugs, non-artificial oral feeding, suction, and hygienic care.
- P. Limitations: I do not wish to limit my Health Care Agent's exercise of his or her discretion and judgment with respect to any decisions regarding my medical care. I give my Agent full and final authority and unlimited discretion to make any medical decisions on my behalf consistent with the provisions set forth in the previous paragraphs. Because I cannot anticipate in advance every medical situation I might be in and what choices I would make in each situation, and in order to guide my Agent in the process of making such difficult decisions and choices for me, I may from time to time write a memorandum or directive to indicate my preferences with respect to the administration, withholding or withdrawal of certain types of treatment. Any such memorandum or directive is intended to provide the guidance for but not to dictate the choices or decisions of my Agent; and it shall not be conclusive or binding on my Agent.

V STATEMENT OF DESIRES

This statement of desires is intended to give my Agent guidance and not to restrict or bind my Agent.

I wish to live and enjoy life for as long as possible, but I do not wish to receive futile medical treatment. I would consider medical treatment futile if the treatment would only postpone my imminent death or prolong an irreversible coma or a permanent vegetative state. If my Agent determines that recommended medical treatment is futile, I instruct my Agent to refuse to give permission to initiate that treatment, and to order the withdrawal of the treatment if it has already been started. This includes but it is not limited to cardiopulmonary resuscitation, mechanical breathing, artificial nutrition and hydration, major surgery, blood or blood products and antibiotics.

In less extreme situations, I do want my life to be prolonged and life-sustaining treatment to be provided or continued if my Agent believes that for me the expected benefits of the treatment outweigh its burdens. In making decisions about initiating or continuing any treatments or procedures, my Agent shall consider the relief of my suffering as well as the likely quality and duration of my life following treatment.

In any case, I wish my Agent to be guided by my desire that all comfort measures be provided to me, so that my last days and hours are as easy and pain-free as possible. To the extent there may be a conflict among the goals, my Agent shall be the sole arbiter of what my choice would be.

VI REVOCATION

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

- A. My execution of a subsequent Health Care Proxy;
- B. My divorce or legal separation from my spouse where my spouse is named as my Health Care Agent.
- C. My notification to my Health Care Agent or a health care provider orally or in writing or by any other act evidencing a specific intent to revoke the Health Care Proxy.

SIGNATURE OF PRINCIPAL

EXECUTED in triplicate in North Reading, Massachusetts, and intended to take effect as a sealed instrument on _____.

XXX XXX, Principal

VII WITNESS

We, the undersigned witnesses each do hereby declare in the presence of the aforesaid Principal, each declare that neither of us has been named as Agent or alternate Agent in this Health Care Proxy and neither of us is related to the agent or alternate agent by blood or marriage. We, further declare that she signed and executed this instrument as her health care proxy in the presence of each of us, that she signed it willingly, that each of us hereby signs this health care proxy as witness in the presence of the Principal, and we do hereby affirm that to the best of our knowledge the Principal appeared to be eighteen (18) years of age or older, of sound mind and under no constraint or undue influence.

WITNESS 1:

Print Name: _____ Signature: _____

Address: _____ Telephone Number: _____

WITNESS 2:

Print Name: _____ Signature: _____

Address: _____ Telephone Number: _____

COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss. _____

Then personally appeared the above named XXX XXX as Principal of the within Healthcare Proxy known to me or satisfactorily proven to be the person whose name is subscribed to the within instrument and acknowledged that she executed the same as her free act and deed for the purposes therein expressed, before me.

Notary Public: XXX XXX
My Commission expires: