New York Health Care Proxy

Statutory form for an adult principal

Complete and execute this document separately from any Power of Attorney

Before signing

Choose an adult agent you trust and discuss your wishes, especially artificial nutrition and hydration. The principal signs and dates in the presence of two adult witnesses. The agent and alternate agent cannot serve as witnesses. A notary is not required for the standard New York form.

Appointment of health care agent

I, _____ (name of principal), hereby appoint:

Agent's name: _____

Agent's home address: _____

Agent's telephone number: _____

as my health care agent to make any and all health care decisions for me, except to the extent I state otherwise.

This health care proxy shall take effect in the event I become unable to make my own health care decisions.

Instructions, wishes, or limits (optional)

NOTE: Although not necessary, and neither encouraged nor discouraged, you may wish to state instructions or wishes, and limit your agent's authority. Unless your agent knows your wishes about artificial nutrition and hydration, your agent will not have authority to decide about artificial nutrition and hydration. If you choose to state instructions, wishes, or limits, please do so below:

_____

I direct my agent to make health care decisions in accordance with my wishes and instructions as stated above or as otherwise known to him or her. I also direct my agent to abide by any limitations on his or her authority as stated above or as otherwise known to him or her.

Alternate agent

In the event the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint:

Alternate agent's name: _____

Alternate agent's home address: _____

Alternate agent's telephone number: _____

Duration, signature, and witnesses

I understand that, unless I revoke it, this proxy will remain in effect indefinitely or until the date or occurrence of the condition I have stated below:

(Please complete the following if you do NOT want this health care proxy to be in effect indefinitely):

This proxy shall expire (specify date or condition):

Signature of principal:

Address of principal:

Date:

Statement by witnesses

I declare that the person who signed or asked another to sign this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence and that person signed in my presence. I am not the person appointed as agent by this document.

Witness 1	Witness 2
Signature:	Signature:
Print name:	Print name:
Address:	Address:
City, State, Zip Code:	City, State, Zip Code:
Date:	Date:

Give copies to the agent, alternate agent, primary care provider, and appropriate family members. Keep the original accessible and review the appointment after major life changes.

Source: New York Public Health Law § 2981