HEALTH CARE PROXY

(1) I, _____, residing at _____, hereby appoint _____, residing at _____, telephone no. _____ (day), and _____ (cell), as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions. If the person I appoint above is unable, unwilling or unavailable to act as my health care agent, then I appoint _____, residing at _____, telephone no. _____ (home) and _____ (cell), as my successor health care agent.

I also appoint the aforesaid _____ to serve as my Personal Representative pursuant to the Health Insurance Portability and Accountability Act of 1996, (Pub. L. 104-191), and its regulations, 45 C.F.R. Section 160 through 164 inclusive, as amended from time to time ("Act").

(2) My Agent(s) and any others named above as Personal Representative(s) shall have the status, power, authority and rights to act immediately as my Personal Representative for all purposes provided in the Act. Therefore, I authorize:

- any health care provider or entity covered by the Act, including but not limited to any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse
- to give, disclose and release to my Agent(s) and Personal Representative(s), without restriction
- any and all of my health information and medical records regarding any past, present, or future medical or mental health condition.

I intend that the authority given to my Agent(s) and Personal Representative(s) pursuant to this Health Care Proxy shall supersede any prior agreement that I may have made with any health care provider to restrict access to or disclosure of my patient records and other protected health information that may be subject to and protected under the Act, and I hereby authorize my Agent(s) and Personal Representative(s) to execute any and all authorizations, releases or other documents necessary to obtain disclosure.

The authority given to my Agent(s) and Personal Representative(s) pursuant to this Health Care Proxy has no expiration date and shall not expire until revoked in writing in either a written document signed by me, or a written document signed by my Agent or Personal Representative, delivered to such individual or organization covered by the Act.

I authorize my Personal Representative to appoint a Patient Advocate for me, who may be any person so designated by my Personal Representative. My Patient Advocate shall have the same right to ask questions and receive information regarding my medical condition(s),

treatment, and any proposed treatment as I and my Personal Representative would have, and the right to be in attendance to me at all times.

I authorize my Agent(s) and Personal Representative(s) to take any and all legal steps necessary to ensure compliance with my instructions to provide access to my protected health information. Such steps shall include resorting to any and all legal procedures in and out of the courts as may be necessary to enforce my rights under the law and shall include attempting to recover attorneys' fees against anyone who does not comply with this Health Care Proxy.

(3) Optional instructions: I direct my health care agent to make health care decisions in accord with my wishes as hereinafter stated and as he/she otherwise knows. I have advised my health care agent and my substitute health care agent(s) as to my wishes concerning artificial nutrition and hydration or use of a ventilator. I hereby confirm that my health care agent and substitute health care agent(s) are authorized to refuse artificial nutrition and hydration or use of a ventilator and to consent to an order not to attempt cardiopulmonary resuscitation (pursuant to Section 2965 of the New York Public Health Law) in accordance with my wishes as made known to them.

(4) Unless I revoke it, this proxy shall remain in effect indefinitely.

(5) Signature: _____
Address: _____
Date: _____

Statement of Witnesses (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 _____

Address _____

Witness 2 _____

Address _____

Witness 3 _____

Address _____