
Appendix G

Sample Healthcare Proxy Form

Below is an example of language used for a Massachusetts healthcare proxy form. It is strongly recommended that individuals adapt the language to meet their own needs and check the specific laws of their state of residence (a helpful Web site is http://www.finance.cch.com/tools/poaforms_m.asp).

MASSACHUSETTS HEALTHCARE PROXY

OF

(CLIENT NAME)

TO ALL PEOPLE CONCERNED WITH MY MEDICAL CARE:

A. APPOINTMENT

I, **(client name)**, residing at **(address)**, _____County, Massachusetts, being a competent adult of at least 18 years of age, of sound mind, and under no constraint or undue influence, hereby appoint the following person to be my HEALTHCARE AGENT under the terms of this document:

NAME:

Address:

Telephone:

In so doing, I create a Healthcare Proxy according to Chapter 201D of the General Laws of Massachusetts. I hereby give my Healthcare Agent the authority to make any and all healthcare decisions on my behalf, subject to any limitations that I state in this document, in the event that, in the future, I should become incapable of making healthcare decisions for myself.

If my original Healthcare Agent is unable or unwilling to serve, I hereby appoint the following person as my Healthcare Agent:

NAME:

Address:

Telephone:

B. POWERS OF HEALTHCARE AGENT

1. I give my Healthcare Agent full authority to make any and all healthcare decisions for me, including decisions about life-sustaining treatment, subject only to any limitations that I state below.

2. My Healthcare 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 to communicate healthcare decisions for myself. This determination shall be made in writing by my attending physician according to accepted standards of medical judgment and the requirements of Chapter 201D of the General Laws of Massachusetts.

3. The authority of my Healthcare Agent shall cease if my attending physician determines that I have regained capacity. The authority shall recommence if I subsequently lose capacity and consent for treatment is required.

4. I shall be notified of any determination that I lack capacity to make or communicate healthcare decisions where there is any indication that I am able to comprehend this notice.

5. My Healthcare Agent shall make healthcare decisions for me only after consultation with my healthcare providers and after consideration of acceptable medical alternatives regarding diagnosis, prognosis, treatments, and their side effects.

6. My Healthcare Agent shall make healthcare decisions for me in accordance with his/her assessment of my wishes, my moral or religious beliefs, or, if such factors are unknown, then in accordance with my Healthcare Agent's assessment of my best interests.

7. My Healthcare Agent shall have the right to receive any and all medical information necessary to make informed decisions regarding my healthcare, including any and all confidential medical information that I would be entitled to receive.

8. If I object to a healthcare decision made by my Healthcare Agent, my decision shall prevail unless it is determined by court order that I lack capacity to make healthcare decisions.

9. The decisions made by my Healthcare Agent on my behalf shall have the same priority as my decisions would have if I were competent over decisions by any other person, except for any limitation I state below or a specific court order overriding this proxy.

10. 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 sedatives and pain-killing drugs, non-artificial oral feeding, suction, and hygienic care.

C. COURT-APPOINTED GUARDIAN

If it is deemed necessary to seek the appointment by a probate court of a guardian of my person, I hereby nominate the persons named herein as my

appointed Healthcare Agent and alternate Healthcare Agent for appointment by such court to serve as such fiduciary.

D. HIPAA RELEASE AUTHORITY

I hereby grant my Healthcare Agent release authority that applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d, as now in effect, and as such law may from time to time hereafter be amended. I intend that my Healthcare Agent be treated as I would be, with respect to my rights regarding the use and disclosure of my individually identifiable health information and/or other medical records.

I hereby authorize any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered healthcare provider, any insurance company or healthcare clearinghouse that has provided treatment or services to me, that has paid for or that is seeking payment from me for such services, to give, disclose and release to my Healthcare Agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition.

The authority given to my Healthcare Agent under this Section D supercedes any prior agreement that I may have made with my healthcare providers with respect to disclosure of my individually identifiable health information.

As long as this Healthcare Proxy remains in full force and effect, the HIPAA release authority given under this Section D has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my healthcare provider.

E. REVOCATION

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

- a. my execution of a subsequent Healthcare Proxy
- b. my divorce or legal separation from my spouse where my spouse is named as my Healthcare Agent
- c. my notification to my Healthcare Agent or a healthcare provider orally or in writing or by any other act evidencing a specific intent to revoke the Healthcare Proxy

SIGNATURE OF PRINCIPAL

I hereby sign my name on this _____ day of _____, _____, to this Healthcare Proxy in the presence of two witnesses.

_____ Client Name

I declare under the penalty of perjury that the persons whose names are subscribed to this instrument appear to be of sound mind and under no duress, fraud, or undue influence.

My Commission Expires: _____