



MASSACHUSETTS HEALTH CARE PROXY FORM

**Name Your Health Care Proxy**

I, \_\_\_\_\_ (the principal – PRINT your name), residing at \_\_\_\_\_ County, Massachusetts, pursuant to Massachusetts General Laws Chapter 201D, appoint the following person to be my Health Care Proxy (also known as my Health Care Agent):

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

If my Health Care Proxy named above is unwilling or unable to serve, I name as an alternate Health Care Proxy:

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**Say What You Want Your Proxy to Do**

I want my Health Care Proxy to be my voice if I am not able to make or express health care decisions for myself. My Proxy shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Proxy’s authority becomes effective if my attending physician determines that I lack the capacity to make or to communicate health care decisions. My Proxy is then to have the same authority to make health care decisions as I would if I had the capacity to make them EXCEPT (here list the limitations, IF ANY, you wish to place on your Proxy’s authority): \_\_\_\_\_

I want my Health Care Proxy to make health care decisions based on my Proxy’s assessment of my personal wishes. If my personal wishes are unknown, my Proxy is to make health care decisions based on my Proxy’s assessment of my best interests. My Proxy should have access to any medical information, including confidential medical information, about me that I would have a right to myself.

**Sign Your Name at the “X” Below**

I am signing the Health Care Proxy form on \_\_\_\_\_, 20\_\_\_\_ at \_\_\_\_\_ am/pm (circle one). Two other people (witnesses) have seen me sign this form (see below).

Sign your name here: X \_\_\_\_\_

*If you are unable to sign the form yourself, you may ask someone to sign for you as long as two witnesses are watching. If this happens, the person signing for you should write his/her name below:*

The principal has asked me to sign this form on his/her behalf, and I have done so in front of the two people listed below.

Printed Name of Person Who Signed: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Date: \_\_\_\_\_

**Have Your Witness Sign**

Two witnesses sign here. The Health Care Proxy or Alternate may not be a witness. The signatures mean the witnesses agree with this statement: *We, the undersigned witnesses, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal. To the best of our knowledge, the Principal appears to be at least 18 years of age, of sound mind, and under no constraint or undue influence. Neither of us is named as the Health Care Proxy or Alternate Proxy in this document.*

Printed Name of Witness #1: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Witness #2: \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Date: \_\_\_\_\_

**Statement of Health Care Proxy and Alternate (optional)**

**Health Care Proxy:** I have been named by the Principal as the Principal’s Health Care Proxy by this Health Care Proxy form. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept the appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. Or if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal’s wishes.

Signature of Health Care Proxy: \_\_\_\_\_ Date: \_\_\_\_\_

**Alternate Proxy:** I have been named by the Principal as the Principal’s Alternate Proxy by this Health Care Proxy form. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. Or if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal’s wishes.

Signature of Alternate Health Care Proxy: \_\_\_\_\_ Date: \_\_\_\_\_