MASSACHUSETTS HEALTH CARE PROXY FORM

I, _____(the principal), residing at_____, _____ County, Massachusetts, pursuant to Massachusetts General Laws Chapter 201D, appoint the following person to be my Health Care Agent:

Name: _____ Phone #: _____

Address:_____ City/State/Zip: _____

If my Health Care Agent named above is not available, I name as an alternate Health Care Agent:

Name: _____ Phone #: _____

Address:_____ City/State/Zip: _____

I give my Health Care Agent authority to make all health care decisions on my behalf if I become incapable of making such decisions for myself, including but not limited to decisions concerning initiation, continuing, withdrawing or refusing any life-prolonging care, treatment, service or procedure, EXCEPT (here list the limitations, IF ANY, you wish to place on your Agent's authority):

_____

_____

_____

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. If my wishes are unknown, my Health Care Agent shall make such decisions for me only in accordance with my Health Care Agent's assessment of my best interests.

My Agent may obtain any and all medical information, including confidential medical information, as I would be entitled to receive. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

My Health Care Agent's authority to act on my behalf shall exist only for the period during which my attending physician determines that I lack capacity to make or communicate health care decisions for myself.

I sign this Health Care Proxy on _____, 20_____ in the presence of two witnesses.

Signed:_____

(If the Principal cannot sign) The principal is unable to sign and at the direction of the principal I have signed his/her name in his/her presence and in the presence of two witnesses.

Name:_____

Street: _____ City/Town: _____

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We, the undersigned witnesses, each declare in the presence of the principal that neither of us has been named as Health Care Agent or alternate Health Care Agent in this Health Care Proxy, and we further declare that the principal signed this instrument as his/her Health Care Proxy, or directed its execution, in the presence of each of us, that each of us signs this Health Care Proxy as witness in the presence of the principal, and that to the best of our knowledge he/she is eighteen (18) years of age or over, of sound mind, and under no constraint or undue influence.

Witness: _____ Printed Name: _____

Address: _____

Witness: _____ Printed Name: _____

Address: _____

Statement of Health Care Agent (optional)

Health Care Agent: I have been named by _____ (the "principal") as the principal's **Health Care Agent** by his or her Health Care Proxy and I hereby accept this appointment. The principal has communicated to me his/her health care wishes at a time of possible incapacity, and I will try to give effect to the principal's wishes. I am not an operator, administrator or employee of a hospital, 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 such a person, I am also related to the principal by blood, marriage or adoption.

Signature of **Health Care Agent:**_____ Date: _____

Statement of Alternate Health Care Agent (optional)

Alternate: I have been named by _____ (the "principal") as the principal's **Alternate Health Care Agent** by his or her Health Care Proxy and I hereby accept this appointment. The principal has communicated to me his/her health care wishes at a time of possible incapacity, and I will try to give effect to the principal's wishes. I am not an operator, administrator or employee of a hospital, 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 such a person, I am also related to the principal by blood, marriage or adoption.

Signature of **Alternate Health Care Agent:**_____ Date: _____