Chautauqua County Health Network
strengthening and promoting quality health care

NEW YORK HEALTH CARE PROXY

(1) I, _____, hereby appoint: _____
(print name)

_____

(print name, home address and telephone number of agent)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. **My agent does know my wishes regarding artificial nutrition and hydration.**

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

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows.

_____

_____

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

_____

_____

(print name, home address and telephone number of agent)

(4) Donation of Organs at Death:

[ ] I **do <u>not</u>** wish to donate my organs, tissues or parts.

[ ] I **do** wish to be an organ donor.

(5) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition I have stated below. This proxy shall expire (specific date or conditions, if desired):

_____

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(6) Signature:_____ Date:_____

Address:_____

Telephone Number: ( ) _____ Date of Birth:_____

Statement by Witnesses (must be 18 or older)
I declare that the person who signed this document appeared to execute the proxy willingly and free from duress. He or she signed (or asked another to sign for him/her) this document in my presence. I am not the person appointed as proxy by this document.

Witness 1:_____

Address:_____

Witness2:_____

Address:_____

I consent to releasing this information to the Health Care Proxy Registry.
Signature: _____ Date:_____
Fax to CCHN at 1-855-214-2967