

## HEALTH CARE PROXY

**TO:** My family, physicians and all  
those concerned with my care

I, \_\_\_\_\_(Your name), presently residing at \_\_\_\_\_Street,  
\_\_\_\_\_ (City or Town), MA. \_\_\_\_\_ (zipcode), and being an adult of sound mind, pursuant to  
Massachusetts General Laws, Chapter 201D, hereby appoint and authorize \_\_\_\_\_ (Name  
of your healthcare agent), presently residing at \_\_\_\_\_ (Health Agent's Address),  
telephone number: \_\_\_\_\_, as my agent to act for me and in my name to make and communicate any and all  
decisions about or relating to my receipt or refusal to accept medical treatment, hospitalization, health care or  
personal care, in any situation in which, as the result of illness, disease, mental deterioration or injury, I am  
incapable of making or communicating a decision with respect to my treatment or care. This authorization includes  
the right to refuse and direct the withdrawal of medical treatment which would prolong my life, and to communicate  
health care decisions to all persons including without limitation my physicians, health care providers and family.

**NOTE: In the space provided below, insert any specific desires, special provisions or limitations which you  
desire:**

I further delegate to my agent the power and authority to select, employ and discharge health care  
personnel, such as physicians, nurses, therapists, hospice care and home health care providers, and other medical  
professionals; to admit or discharge me (including transfer from another facility) from any hospital, hospice, nursing  
home, adult home or other medical care facility; and to apply for public benefits to defray the cost of health care,  
and to contract in my name and on my behalf for all health care services, including without limitation medical,  
nursing and hospital care, as my agent may deem appropriate. I confirm that I shall be and remain personally liable  
for the payment of all such care and services to the same extent as if I had personally contracted therefor.

{**OPTIONAL**} I authorize my agent to donate all or any part of my body for transplantation, therapy,  
advancement of medical or dental science, research, or other medical, educational or scientific purpose, or to  
otherwise direct the disposition of my remains.

I further authorize my agent to request, receive and review any information regarding my physical  
or mental health, including without limitation medical and hospital records; to execute on my behalf any releases or  
other documents that may be required in order to obtain this information; and to consent to the disclosure of this  
information. I authorize my agent to execute on my behalf any documents necessary or desirable to implement the  
health care decisions that my agent is authorized to make pursuant to this document, including without limitation all  
documents pertaining to a refusal to permit medical treatment, or authorizing the leaving of a medical facility  
against medical advice, or any waivers or releases from liability required by a physician or health care provider.

I reserve the power to revoke this document at any time by communicating my intent to revoke in  
any manner in which I am able to communicate.

The authority of my agent shall become effective when I can no longer make or communicate my  
own medical decisions. The determination of whether I can make or communicate my own medical decisions is to

be made by my attending physician. I have read the foregoing notice concerning the legal consequences of my executing this document. I have discussed my wishes with, and have carefully selected, my agent.

**IN WITNESS WHEREOF**, I have executed this instrument, as my free and voluntary act and deed, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
YOUR NAME

WITNESS:

We, (Witness #1) \_\_\_\_\_ and ( Witness #2) \_\_\_\_\_, each hereby attest and declare under penalty of perjury under the laws of the Commonwealth of Massachusetts that: (1) the foregoing instrument was personally signed by \_\_\_\_\_ (Your name) in my presence, and thereupon I, at his/her request and in his/her presence and in the presence of the other witnesses, have hereunto subscribed my name as a witness; (2) I did not sign the above signature of \_\_\_\_\_ (Your name) for or at his/her direction; (3) I personally know \_\_\_\_\_ (Your name) and believe him/her to be of sound mind and under no constraint, duress, fraud or undue influence; (4) I am not related to \_\_\_\_\_ (Your name) by blood, marriage or adoption; (5) I am not entitled (to the best of my knowledge and belief) to any portion of the estate of \_\_\_\_\_ (Your name) upon his/her death under any will or codicil or by operation of law; (6) I do not have any present or inchoate claim against any portion of the estate of \_\_\_\_\_ (Your name); (7) I do not have any financial responsibility for the medical care of \_\_\_\_\_ (Your name); (8) I am not a physician or an employee of any physician, and I am not an operator or employee of, or patient in, any hospital, health care provider, residential care facility, community care facility or similar institution; (9) I am not a person named as agent in this instrument; and (10) I am at least 18 years of age.

Dated: \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
residing at \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
residing at \_\_\_\_\_  
\_\_\_\_\_