

# Massachusetts Health Care Proxy Information, Instructions and Form



Boston Children's Hospital

## **An Overview of the Massachusetts Health Care Proxy Law**

The Massachusetts Health Care Proxy law (Massachusetts General Laws, Chapter 201D) authorizes a competent adult who is age eighteen or older to appoint a Health Care Agent. Your agent will have full authority to make any healthcare decisions, when you are unable to make or communicate those decisions.

Boston Children's Hospital (BCH) has developed the attached legal document and instructions for our patients and their families that meets the requirements of the Massachusetts law as well as relevant court cases regarding health care proxies. This legal form can be used throughout your care at BCH or another healthcare facility/provider.

## **Responsibilities of the Health Care Agent**

You, the principal, can appoint anyone, with the exception of a health care clinician or staff at a health care facility (including but not limited to a hospital, community health center, or long term care facility). Please note, a clinician or staff who is related to you by blood, marriage, or adoption may be appointed as the Health Care Agent.

Using the Boston Children's form, your agent will be authorized to make decisions about your medical and/or mental health care, authorize admission or discharge, and access confidential medical information only when you are, for some reason, unable to do that yourself. This will include the ability to consent to or refuse any medical treatment, including decisions about life sustaining medical treatment.

The purpose of the BCH form is to allow your agent to act on your behalf if you are temporarily unconscious, in a coma, or have some other medical or mental health condition in which you cannot make or communicate health care decisions. There must be a determination by your treating health care provider, in writing, that you lack the capacity or ability to make health care decisions. Please note that a court may also determine that you lack capacity and allow the Health Care Agent to make decisions.

Your agent will make decisions regarding care and treatment based on their determination of what is in your best interest. So it is strongly advised that you communicate with your Health Care Agent in advance so they are aware of your wishes regarding any upcoming or future medical and/or mental health care and treatment.

Under Massachusetts law, your clinicians will honor your wishes if you disagree with any care and treatment recommended by your health care agent – provided that your clinician has determined that you have capacity to make such decisions.

The Healthcare Proxy will remain in effect until either you (the principal) regains capacity as determined by the treating clinician, or a court of competent jurisdiction has determined the Health Care Proxy should be terminated.

**DO NOT SEND THIS PAGE TO MEDICAL RECORDS**



## Instructions to Complete the Form

### Section (1)

The Principal should print out their name, and then provide the full name, address, telephone and email of your chosen Health Care Agent. You may, but are not required, also name an alternate agent if your primary Health Care Agent is not able or unwilling to serve.

### Section (2)

The Boston Children's Hospital proposed legal document provides a detailed authorization for your Health Care Agent. Within this section, you may also set any limitations on certain healthcare services or decisions by your agent. This is not required, so if your Agent should have full authority to act for you, please leave this area blank.

### Section (3)

The principal should then sign the form acknowledging that they have chosen and authorized their agent to so act. Please note, if the principal is unable to sign the form, another person (who is not the agent and not one of the two witnesses) should sign the principal's name as well as sign the form.

Your two witnesses must then sign the form with their contact information. Witnesses are required to sign verifying that the principal does not appear to be under any constraint or undue influence to sign the form. Under the Massachusetts law, the witnesses cannot be related to the principal by blood or marriage, and should not be entitled to or have any claims on the estate of the principal. BCH clinicians and/or other staff are allowed to sign as witnesses if there are no other parties available.

## Where should the Health Care Proxy be Kept?

The principal should always keep the original signed form. Copies of the form should be provided to all medical providers (including but not limited to any hospital, community health center, long term care facility, and your provider's office/clinic) to be maintained in the principal's medical record. A copy should also be provided to your Health Care Agent to use with any other providers that will be involved in the principal's future care and treatment.

## Cancelling the Health Care Proxy?

The following may be used to cancel or revoke the Health Care Proxy:

1. The principal signs another Health Care Proxy at a later date;
2. The principal notifies their agent, clinician, or other health care provider staff that they want to revoke the proxy, provided the principal has capacity. This can be done orally, in writing, or other action (including destroying the original);
3. A court of competent jurisdiction declares the Health Care Proxy to be terminated; or
4. The principal changes the agent, becomes legally separated from, or divorces the named health care agent.

## DO NOT SEND THIS PAGE TO MEDICAL RECORDS



Name: \_\_\_\_\_

BCH MRN#: \_\_\_\_\_

DOB: \_\_\_\_\_

Gender: \_\_\_\_\_

**MASSACHUSETTS HEALTH CARE PROXY**

**(1)** I, \_\_\_\_\_, appoint as my principal Health Care Agent

\_\_\_\_\_  
\_\_\_\_\_

*(print name, home address, telephone, and email of health care agent)*

If my agent is unable or unwilling to serve, I appoint as an alternate health care agent:

\_\_\_\_\_  
\_\_\_\_\_

*(print name, home address, telephone, and email of health care agent)*

**(2)** I hereby direct my Agent to so act as my healthcare proxy to have full power, authority and discretion to review any health information as well as make any and all health care consultation, treatment, and/or care coordinating decisions for me regarding my own medical and/or mental health care, including decisions about life sustaining medical treatment, without any limitations. This declaration shall be honored by my family and my health care providers as the final expression of my desires regarding my future care. I further expressly revoke any and all Health Care Proxies that may have been signed prior to this Proxy. The determination regarding my ability to make health care decisions is to be made by my treating healthcare provider. Furthermore, I hereby agree that any third party receiving a copy of this instrument via mail, fax, or other electronic means, shall so act hereunder. I agree to hold harmless any such third party from and against any and all claims that may arise by reason of having relied on the provisions of this instrument. Unless so listed here,

limitations on my Agent's authority shall include: \_

**(3)** Principal Signature: \_\_\_\_\_ Date: \_\_\_\_\_

In the case the Principal is unable to sign, I am signing this proxy form on behalf of the Principal (including writing their name above) in the presence of the Principal and two witnesses.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Witness Statement**

I hereby witness this declaration and attest that I have met Principal and believe they are of sound mind, at least eighteen years of age, and under no constraint or undue influence. I declare under penalty of perjury of law that the foregoing is true and correct in our presence this

\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

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

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

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

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