



What does the Massachusetts Health Care Proxy Law allow?

The Health Care Proxy is a legal document that allows you to name someone to make health care decisions for you if, for any reason and at any time, you become unable to make or communicate those decisions. It is an important document, however, because it concerns not only the choices you make about your health care, but also the relationships you have with your physician, family, and others who may be involved with your care. Read this and follow the instructions to ensure that your wishes are honored.

Under the Health care Proxy Law (Massachusetts General Laws, Chapter 201D), any competent adult 18 years of age or over may use this form to appoint a Health Care Agent. You (the "Principal") can appoint anyone EXCEPT the administrator, operator, or employee of a health care facility such as a hospital or nursing home where you are a patient or resident UNLESS that person is also related to you by blood, marriage, or adoption.

What can my Agent do?

Your Agent will make decisions about your medical or mental health care only when you are, for some reason, unable to do that yourself. This means that your agent can act for you 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. Your Agent cannot act for you until your doctor determines, in writing that you lack the ability to make health care decisions.

Acting with your authority, your agent can make any health care decision that you could, if you were able. If you give your Agent full authority to act for you, he or she can consent to or refuse any medical treatment, including decisions about life-sustaining treatment.

Your agent will make decisions for you only after talking with your doctor or health care provider and after fully considering all the options regarding diagnosis, prognosis, and treatment of your illness or condition. Your Agent has the legal right to get any information, including confidential medical information, necessary to make informed decisions for you.

Your Agent can make health care decisions for you according to your wishes or according to the Agent's assessment of your wishes, including your religious or moral beliefs. You may wish to talk first with your doctor, religious advisor, or other people before giving instructions to your Agent. It is very important that you talk with your agent so that he or she knows what is important to you. If your Agent does not know what your wishes would be in a particular situation, your agent will decide based on what he or she thinks would be in your best interests. After your doctor has determined that you lack the ability to make health care decisions, if you still object to any decision made by your Agent, your own decision will generally be honored unless a Court determines that you lack capacity to make health care decisions. Your Agent's decisions will have the same authority as yours would, if you were able, and will be honored over those of any other person, except of any limitation you yourself make, or except for a court Order specifically overriding the Agent

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How do I fill out the form?

Section 1

At the top of the form, print your full name and address. Print the name, address, and phone number of the person you choose as your Health Care Agent. (Optional: If your Agent might not be available at any future time, you may name a second person as an Alternate Agent.)

Section 2

Review the authority outlined for your Agent to make health care decisions on your behalf and sign the form. Setting limits on your Agent's authority might make it difficult for your Agent to act for you in an unexpected situation. If you want your Agent to have full authority to act for you, leave the limitations space blank. However, if you want to limit the kinds of decisions you would want your Agent or Alternate Agent to make for you, include them in the blank. *Note if you are physically unable, have someone other than either witness sign your name at your direction. The person who signs your name for you should put his/her own name and address in the spaces provided.*

Section 3

Have your witnesses enter the date, sign their names and print their contact information. Please note that your witnesses cannot be related to you by blood or marriage, cannot be someone who has or may have any claim on your estate, and cannot be entitled to any portion of your estate by any Will or by operation of law. They must also be aware that they are signing that they are NOT aware of any constraint or undue influence being exercised upon you to sign the proxy form.

Who should have the original and copies?

The patient should always keep the original and make several copies, giving a copy to each of your medical providers (clinicians and hospitals) as well as other important contacts (e.g., your health plan). Your agent, alternative agent and any one else involved in your healthcare decision making (caregivers) should also be given a copy.

How can I revoke or cancel the document?

Your Health Care Proxy is revoked when any of the following four things happens:

1. You sign another Health Care Proxy later on.
2. You legally separate from or divorce your spouse who is named in the Proxy as your Agent.
3. You notify your Agent, your doctor, or other health care provider (orally, in writing, or by some other actions) that you want to revoke your Health Care Proxy.
4. You do anything else that clearly shows you want to revoke the Proxy, for example, tearing up or destroying the Proxy, crossing it out, telling other people, etc.

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Name: _____

BCH MRN#: _____

DOB: _____

Gender: _____

MASSACHUSETTS HEALTH CARE PROXY

(1). I, _____, born on, _____
_____ Date of Birth
Print Principal Name

residing at _____
Address

appoint as my Health Care Agent:

Print Health Care Agent Name

Telephone # E-mail

OPTIONAL: If agent is unwilling or unable to serve, then I appoint:

Print Alternate Health Care Agent Name

Telephone # E-mail

(2) I hereby direct my Agent to so act as my healthcare proxy to have full power, authority and discretion to 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. I further declare that 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 hereby 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 and shall contain his/her medical opinion regarding the anticipated duration of said lack of capacity. 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, the limitations on my Agent's authority shall include:

Principal Signature Date
As the Principal is unable to sign, but can otherwise indicate their intent, I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

Signature **(Print Name)** Date
Address

(3) Witness Statement

I hereby witness this declaration and attest that I have met Principal and believe they are of sound mind. I declare under penalty of perjury under the laws of the Commonwealth of Massachusetts that the foregoing is true and correct in our presence this _____ day of _____, 20____.

Witness Signature #1 **(Print Name)** Date
Address

Witness Signature #2 **(Print Name)** Date
Address