HEALTH CARE PROXY AND LIVING WILL*

TO MY FAMILY, MY DOCTORS, MY HEALTH CARE AGENT AND OTHERS CONCERNED WITH MY CARE:

A. HEALTH CARE PROXY

I, [name], residing at [address], am making this declaration while in full possession of my faculties, and after long and careful consideration.

I hereby appoint [name], residing at [address], telephone [number], as my health care agent to accept, refuse or make health care decisions about my treatment and hospitalization in accordance with my wishes and instructions as stated herein or as otherwise known to him/her in the event that I am unable to make such decisions myself. In the event that [name] is unable, unwilling or unavailable to act as my health care agent, I hereby appoint [name] residing at [address], telephone [number], as my alternate health care agent to make such health care decisions in the event that I am unable to make such decisions myself.

I intend for my health care agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 1320d and 45 C.F.R. pts.160-164. I authorize: any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care clearing house that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my health care agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition of every nature and kind. The authority given to my health care agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information.

I understand that unless I revoke it, this Health Care Proxy shall remain in effect indefinitely. It is my direction that my health care agent act in accordance with my wishes set forth below in my Living Will.

B. LIVING WILL

I, [name], residing at [address], am making this declaration while in full possession of my faculties, and after long and careful consideration.

I do not wish to be kept alive by various measures if there is no reasonable expectation of my being able to enjoy a meaningful quality of life due to my medical condition.

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* Provided by Sanford J. Schlesinger, Esq., of Schlesinger Gannon & Lazetera LLP.

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Accordingly, I direct that life-sustaining procedures should be either withheld or withdrawn if I have an illness, disease or injury, or experience extreme mental deterioration, and if doctors selected by me or by my family determine that there is no reasonable expectation that I will recover to a sufficient extent to enable me to enjoy a meaningful quality of life. It is obviously impossible to foresee all of the circumstances in which I would feel that this direction is applicable, but without in any way limiting the general scope of the foregoing direction, I would certainly include (a) my being in a coma for a sufficient period, or my suffering such brain, heart or other physical damage, that in either case it is unlikely that I would be able to perform enough bodily functions to render my life bearable and enable me to have some enjoyment out of life, or (b) my losing my mental faculties to the extent of being unable to recognize my family and friends or my surroundings, or to understand where I am and what I am doing, or to communicate coherently, and there is no reasonable expectation that this situation will be reversed.

The life-sustaining procedures that I would want withheld or withdrawn include, but are not limited to, surgery, respiratory support, artificially administered nutrition and hydration, and antibiotics. In addition, I would want cardiopulmonary resuscitation withheld and I specifically consent to the issuance of a Do Not Resuscitate Order.

In the circumstances described above I direct that treatment be limited to measures calculated to relieve my pain or to provide me comfort.

If it does not impose an undue burden on my friends or my family, I would like to live out my last days at home or in a hospice or similar facility rather than a hospital.

I understand that these directions may result in shortening my life, but, on the basis of my experience with others and my own self-examination, I prefer to have my life shortened than to continue to exist without a meaningful quality of life. I prefer it both for myself and for my loved ones, whom I want to spare the pain and the expense that would be involved in prolonging my life in the circumstances described.

I have written the foregoing directions to express my legal right to refuse treatment. I recognize (a) that there may come a time when people question my ability to understand what directions I might then be giving, and their consequences, and (b) that some recent court decisions have required fairly specific direction. I have therefore made these directions as inclusive and explicit as I know how. Since I cannot foresee all the specific circumstances which can arise, I direct that if circumstances do arise which are not described above, the general principles I have set forth be applied in the spirit in which I have written this. I expect my family, my doctors, my health care agent and others concerned with my care, to regard themselves as legally and morally bound to act in accordance with my wishes.

I understand that unless I revoke it, this Living Will shall remain in effect indefinitely.

Signed: _____ Dated: _____
[name]

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. He/She signed this document in my presence

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and the other witnesses signed in my presence. I am not the person appointed as agent by this document.

Witness: _____

Address: _____

_____

Witness: _____

Address: _____

_____

Witness: _____

Address: _____

_____

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