GLP-WESTERN NEW YORK UROLOGY ASSOCIATES
Health Care Proxy Information & Instructions

About the Health Care Proxy

This is an important legal form. Before signing this form, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or provide life-sustaining treatment.
3. Unless your agent knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse or consent to those measures for you.
4. Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

*** If I become terminally ill, I do/don't want to receive the following treatments...**
*** If I am in a coma or unconscious, with no hope of recovery, then I do/don't want...**
*** If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want...**
*** I have discussed with my agent my wishes about_____, and I want my agent to make all decisions about these measures.**

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list of the treatments about which you may leave instructions:

* artificial respiration
* psychosurgery
* artificial nutrition and hydration (nourishment provided by feeding tube)
*dialysis
* transplantation
* cardiopulmonary resuscitation (CPR)
* blood transfusions
* antipsychotic medication
* abortion
* electric shock therapy
* sterilization
* antibiotics

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker, before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. You do not need a lawyer to fill out this form.

You may choose any adult (over 18), including a family member or close friend, to be your agent. If you select a doctor as your agent, he/she may have to choose between acting as your agent or as your attending doctor; a physician cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home, or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask the staff at the facility to explain those restrictions.

You should tell the person you choose that he/she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object. You can cancel the control given to your agent by telling him/her or your health care provided orally or in writing.

Filling Out the Proxy Form

Item (1) Write your name and the name, home address, and telephone number of the person you select as your agent.
Item (2) If you have special instructions for your agent, you should write them here. Also, if you wish to limit your agent's authority in any way, you should say so here. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.
Item (3) You may write the name, home address, and telephone number of an alternate agent.
Item (4) This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire.
Item (5) You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Two witnesses of at least 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.

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HEALTH CARE PROXY

(1) I,_____

hereby appoint _____
(name, home address, and telephone number)

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if 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/she otherwise knows. (Attach additional pages if necessary.)

_____

_____

_____

_____
(Unless your agent knows your wishes about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration. (See instructions for filling out the proxy form.)

(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.

_____
(name, home address, and telephone number)

_____

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

_____

(5) Signature _____

Address _____

Date _____

Statement by Witnesses (must be 18 or older)
I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his/her own free will. He/She signed (or asked another to sign for him/her) this document in my presence.

Witness 1 _____

Address _____

Witness 2 _____

Address _____