UMASS MEMORIAL HEALTH

MASSACHUSETTS HEALTH CARE PROXY

☐ HealthAlliance-Clinton Hospital
☐ Marlborough Hospital
☐ UMass Memorial Health - Harrington Hospital
☐ UMass Memorial Medical Center
☐ UMass Memorial Medical Group | Location: _____

NAME:

BIRTHDATE/AGE: SEX:

MEDICAL RECORD NUMBER:

HAR / CSN ACCOUNT NUMBER:

PRINT CLEARLY IN INK OR APPLY PATIENT LABEL

1

I, _____, residing at
(print your name here)

_____
(street address) (city/town) (state)

appoint as my Health Care Agent: _____
(name of person chosen as Agent) (relationship to patient)

of _____
(street address) (city/town) (state) (phone)

(**Optional:** If my Agent is unwilling or unable to serve, then I appoint as my **Alternate**:

_____, of
(name) (relationship to patient)

_____.)
(street address) (city/town) (state) (phone)

My agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to change if any limitations have been written below, if I am unable to make health care decisions for myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list the limitations, if any, you wish to place on your AGENT'S authority):

I direct my Agent to make health care decisions based on his/her assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on his/her assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original.

Note: You should not choose as your health care agent an employee or member of the health care facility in which you are now or expect to be a patient, unless you are related to that person by blood, marriage or adoption.

Signed: _____ **Date:** _____

Complete only if Principal is physically unable to sign: I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

_____
(name)

_____
(street address) (city/town) (state)

WITNESS STATEMENT: We, the undersigned, each witnessed the signing of the Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate in this document.

Witness #1: _____ Witness #2: _____
(signature) (signature)

Name (print): _____ Name (print): _____

Address: _____ Address: _____

_____ _____