White Plains Hospital
WHITE PLAINS, NY 10601

Health Care Proxy

Addressograph – if no plate, Print Patient's Name, Chart No., Room No.

(1) I,_____ hereby appoint *(name, address, phone 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 only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent – If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint

(name, address, phone number) _____
as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*:

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: _____

☐ My health care agent knows my wishes about artificial nutrition and hydration (i.e. feeding tubes) _____

(5) Your Identification *(print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional - Organ and/or Tissue Donation: I hereby make an anatomical gift, to be effective upon my death, of: (check any that apply)

☐ Any needed organs and/or tissues ☐ The following organs and/or tissues ☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)* 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 or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Name *(print)* _____

Signature _____ Date _____

Address _____

Witness 2

Name *(print)* _____

Signature _____ Date _____

Address _____