

Health Care Agent Disclosure Statement

Before signing this document, you should know these important facts:

This document gives the person you name as your agent the power to make health care decisions for you now or later when you are no longer able to make them yourself.

You should choose as your agent

- someone you trust,
- someone who knows you and will be guided by your values
- someone who will listen to you
- someone who will be comfortable making hard decisions.

Your agent must be is at least 18 years old. You cannot appoint your doctor or nurse or someone who works for them. Also, you cannot appoint your home provider unless the person is a relative.

You should make sure that your agent knows what kind of medical care you want. Your agent will have the same power to make decisions about your health care as you would have. Your agent will have the right to look at your medical records.

Even after you have signed this document, you may make health care decisions for yourself as long as you are able to. Treatment cannot be given to you or stopped over your objection. You have the right to take back the power you give to your agent. You must do this by telling your doctor and the agent. It is best to do this in writing.

Give your agent the original signed copy of this document. Also be sure your doctor, hospital, and dentist have a copy.

This document may not be changed once you have signed it. If you want to make changes in the document, you must make an entirely new one.

Appointment of My Health Care Agent

I, _____ (print name) _____ (date of birth),
want _____ (print name of agent)
to make health care decisions for me.

I want my agent to make any health care decisions my doctor thinks I
am unable to make for myself.

If my agent cannot act for me, I appoint
_____ (name of another person)

SPECIAL WISHES. If there are any special things you want your agent to do
or *not* do when making decisions for you, write them here. Examples are
religious beliefs about health treatment or certain kinds of treatment you do
not want to have.

HOW TO CONTACT MY AGENT:

Address _____

Telephone (day) _____ (evening) _____

(cell) _____

Email _____

HOW TO CONTACT MY ALTERNATE AGENT:

Address _____

Telephone (day) _____ (evening) _____

(cell) _____

Email _____

SIGNED _____ **Date** _____

To go into effect, this document must be signed by two witnesses who are at least age 18 and who were present when you signed above. The witnesses must be people *other than* your agent, alternate agent, your spouse, brother, sister, adult child or grandchild, or someone who might benefit from your death.

I declare that the principal appears to understand what he or she is signing and that he or she is signing of his/her own free will and was under no threat, undue influence or pressure to sign.

Witness 1: (sign and print name) _____

Address: _____

Telephone Number _____ Today's date _____

Witness 2: (sign and print name) _____

Address: _____

Telephone Number _____ Today's date _____