

Massachusetts Health Care Proxy Assignment Instructions

— Authorized by the Massachusetts General Laws, Title II, Chapter 201D, 2005 —

I. What is a Health Care Proxy?

Every adult age 18 or older and of sound mind has the right to name a Health Care Proxy. A Health Care Proxy is a person you choose to make medical decisions on your behalf if you should become incapacitated and unable to communicate your wishes about what medical treatment you do or do not want. You may give your proxy the authority to make any and all medical decisions, or you may limit his or her authority. You may also designate an alternate proxy in the event that your original proxy is unable or unwilling to serve in that capacity.

Your proxy has the authority to make medical decisions on your behalf *only* if your attending doctor determines that you are unable to communicate your wishes. Your proxy's orders about your medical care shall override any objections by your next of kin (if your proxy is different from your next of kin). If you should recover and become able again to communicate your wishes about medical treatment, your proxy's authority immediately ends.

II. Who Can Serve as Your Health Care Proxy

You may choose anyone you wish (subject to the exceptions listed below in Section III) to serve as your Health Care Proxy. Your proxy may be, but *does not have to be*, your legal next of kin or a family member. You should choose a proxy who understands what decisions you would make about your medical care if you could speak, and whom you trust to carry those wishes out.

III. Who Cannot Serve as Your Health Care Proxy

The following people **cannot** serve as your proxy:

a. An operator, administrator, or employee of any health care facility providing you care at the time you execute this assignment form. **EXCEPTION** — such a person **can** serve as your proxy if he or she is related to you by blood, marriage, or adoption.

IV. Physician/Facility Refusal to Honor Proxy's Directions

Massachusetts law allows a physician, private facility, or other individual health care provider to refuse to honor the directions of your proxy if those directions conflict with the moral or religious views of the physician, private facility, or other individual health care provider. **HOWEVER**, if a physician or other provider refuses to honor your proxy's directions, the physician or provider **must** transfer your care to a provider who will honor your proxy's

directions. If the provider is unable to arrange such a transfer, that provider must either honor your proxy's directions or must go to court for a decision.

V. Witnesses

Two competent adults must witness your Health Care Proxy form. However, your Health Care Proxy him or herself **cannot be one of these witnesses.**

VI. Right to Revoke This Assignment

You have the right to revoke your proxy's authority to make health care decisions for you **at any time.** You may revoke this authority orally or in writing (it is **strongly recommended that you revoke the authority in writing**).

Massachusetts Health Care Proxy Assignment

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I, _____, being at least 18 years of age, in sound mind, and under no duress or pressure, do hereby designate _____, to be my Health Care Proxy, should I become incapacitated and unable to communicate my wishes about my medical care. I authorize my Health Care Proxy to make any and all medical decisions on my behalf, with the exception of any limitations listed below. If my original Health Care Proxy is unable or unwilling to make decisions on my behalf, I designate _____ to be my Alternate Health Care Proxy.

(Check one)

___ A. I give my Health Care Proxy full and complete authority to make any and all medical decisions on my behalf

___ B. I place the following limitations on the decision-making powers of my Health Care Proxy:

I understand that my Health Care Proxy's authority will become effective if my attending physician determines that I lack the capacity to make or to communicate my health care decisions. I also understand that if I should regain this capacity, my Health Care Proxy's authority terminates immediately and that all decision-making authority returns to me.

(your signature)

(date)

WITNESSES
(two required)

I, _____, affirm that the above person, _____, appeared to be at least 18 years of age, of sound mind, under no constraint or undue influence, and did sign this Health Care Proxy in my presence.

(witness signature)

(date)

I, _____, affirm that the above person, _____, appeared to be at least 18 years of age, of sound mind, under no constraint or undue influence, and did sign this Health Care Proxy in my presence.

(witness signature)

(date)