NY Connects
Your Link to Long Term Services and Supports

of Chautauqua County

(800) 342-9871 716-753-4582

New York Health Care Proxy

(Please be sure to fill in all shaded boxes)

(1) I, __________, Date of Birth: ___ / ___ / ___

hereby appoint:

Name:

Address: City: State: Zip Code:

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.

My agent does know my wishes regarding artifical nutrition and hydration.

This Health Care Proxy shall take effect in the event 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 or she otherwise knows.

____

____

____

(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:

Address: City: State: Zip Code:

Phone Number:

(4) Donation of Organs at Death:

[ ] I **DO NOT** wish to donate my organs, tissues or parts

[ ] I **DO** wish to be an organ donor

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

____

____

(6) Signature: Date of Birth: ___ / ___ / ___

Address: City: State: Zip Code:

PO Box Phone Number:

Statement by Witnesses (must be 18 or older)--THIS AREA MUST BE FILLED OUT WITH *TWO* WITNESSES

I declare that the person who signed this document appeared to execute the proxy willingly and free from duress. He or she signed (or asked another to sign for him/her), this document in my presence.

I AM NOT THE PERSON(S) APPOINTED AS PROXY BY THIS DOCUMENT

Witness #1:

Address: City: State: Zip Code:

Witness #1:

Address: City: State: Zip Code:

I consent to releasing this information to the Health Care Proxy Registry

Signature: Date: ___ / ___ / ___

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STEPS TO FOLLOW WHILE FILLING OUT YOUR HEALTH CARE PROXY:

1. Think about what is important to you and what health care wishes you want carried out if you are unable to communicate for yourself and appoint a health care agent you are confident could speak for you should that situation arise.

2. Talk to your agent and family about your wishes

3. Put your wishes in writing using a Health Care Proxy Form (see reverse side)

4. If you receive health care services in Chautauqua County, New York and would like your Health Care Proxy to be available online to area healthcare professionals, choose one of the following three options to submit your proxy to the registry.

**Mail a completed copy of your Health Care Proxy to:

Chautauqua County NY Connects
7 North Erie Street
HRC Building
Mayville, NY 14757

**Send copy to our secure fax at 716-753-4844

**Give a completed copy to your health care provider

Please make a copy of your Health Care Proxy to keep for your records

To learn more about Health Care Proxies call NY Connects at:
Mayville (716) 753-4582
Jamestown (716) 661-7582
Dunkirk (716) 363-4582