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Legal Forms & Services

FirstName LastName

MASSACHUSETTS HEALTH CARE DIRECTIVE & LIVING WILL

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive & Living Will in Massachusetts

After printing your document, you will need to finalize it. Below are the steps:

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses
3. Have witnesses sign and date
4. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives and living wills, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive and living will. Review your state's laws on witness requirements for health care directives and living wills.

HEALTH CARE DIRECTIVE & LIVING WILL

FOR

FirstName LastName

This document includes the following:

> Health care proxy appointing a health care agent to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my health care agent should act in my best interest.

MASSACHUSETTS HEALTH CARE PROXY

APPOINTMENT

I, FirstName LastName, being a competent adult at least 18 years of age or older and of sound mind, hereby appoint the following person to be my health care agent if I lack capacity to make or communicate health care decisions for myself:

Name:	FirstName LastName
Relationship:	Spouse
Address:	111 Street Address
	City, Massachusetts 12345
Phone:	555-555-5555
Email:	name@email.com

ALTERNATE APPOINTMENT

If my primary health care agent is not willing, able, or reasonably available, I appoint the following person to be my health care agent:

Name:	FirstName LastName
Relationship:	Son
Address:	222 Street Address
	City, Massachusetts 12345
Phone:	555-555-5555

Email: name@email.com

POWERS OF HEALTH CARE AGENT. My health care agent shall have the authority to make any and all health care decisions on my behalf that I could make, including decisions about life-sustaining treatment, subject to any express limitations.

My agent shall consult with my health care providers and after full consideration of acceptable medical alternatives regarding diagnosis, prognosis, treatments, and their side effects, my agent shall make health care decisions in accordance with an assessment of my wishes, including my religious and moral beliefs. If my wishes are unknown, my agent shall make decisions in accordance with an assessment of my best interests.

Limitations on Health Care Agent's Powers:

I do not wish to limit the authority of my health care agent at this time.

WHEN MY AGENT'S POWER IS EFFECTIVE

This power shall be effective after a determination is made, pursuant to the provisions of Massachusetts General Laws Chapter 201D, Section 6, that I lack the capacity to make or to communicate my own health care decisions. The determination shall be in writing and shall contain the attending physician's opinion regarding the cause and nature of my incapacity as well as its extent and probable duration.

ACCESS TO MY HEALTH CARE INFORMATION

My agent shall have the right to receive any and all medical information necessary to make informed decisions regarding my health care, including any and all confidential medical information that I would be entitled to receive.

END-OF-LIFE HEALTH CARE INSTRUCTIONS

I do not wish to leave instructions for my end-of-life health care at this time.

SIGNATURES

This document must be signed and dated by me. It also must be verified by two witnesses and signed and dated when it is witnessed.

I, FirstName LastName, sign this directive voluntarily and declare I am capable of understanding the instructions I have given and the choices I have made therein. I understand that I may revoke this directive at any time prior to my incapacity.

My Signature: _____

Date signed: _____

If I cannot sign my name, I ask the below named person to sign for me.

Signature: _____

Printed Name:_____

TWO WITNESSES

Witness One. On _____ (date), FirstName LastName (name) appeared before me and acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- The principal appears to be at least 18 years of age, of sound mind, and under no constraint or undue influence.
- I am at least 18 years of age.
- I am not named as a health care agent or an alternate health care agent in this document.

Witness One Signature: _____

Witness One Printed Name: _____

Witness One Address: _____

_____

Witness One Phone: _____

Witness Two. On _____ (date), FirstName LastName (name) appeared before me and acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- The principal appears to be at least 18 years of age, of sound mind, and under no constraint or undue influence.
- I am at least 18 years of age.

- I am not named as a health care agent or an alternate health care agent in this document.

Witness Two Signature: _____

Witness Two Printed Name: _____

Witness Two Address: _____

_____

Witness Two Phone: _____