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Legal Forms & Services

FirstName LastName

NEW YORK HEALTH CARE DIRECTIVE

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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 in New York

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, 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. Review your state's laws on witness requirements for health care directives.

LIVING WILL
FOR
FirstName LastName

This document includes the following:

Health care proxy designating 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.

Instructions and wishes for health care to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

HEALTH CARE PROXY

I, FirstName LastName, being an adult of sound mind, hereby appoint the following individual as my health care agent to make any and all health care decisions for me, except to the extent I state otherwise, in the event I become unable to make my own health care decisions:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, New York 11111

Phone: 1111111111

Email: emailaddress@email.com

In the event the person appointed above is unable, unwilling, or unavailable to act as my health care agent, I hereby appoint:

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, New York 11111

Phone: 1111111111

Email: emailaddress@email.com

AUTHORITY OF HEALTH CARE AGENT: I direct my agent to abide by any limitations on their authority as stated below or as otherwise known to my agent. I also direct my agent to make health care decisions in accordance with my wishes and instructions as stated below, if applicable, or as otherwise known to my agent. If my wishes are not reasonably known and cannot with reasonable diligence be ascertained, I direct my agent to make health care decisions in accordance with my best interests.

Limitations on Agent's Authority: I do not wish to limit the authority of my health care agent at this time.

Life-Sustaining Treatment:

_____☑ If I am diagnosed as having an incurable or irreversible medical condition, including a terminal condition or permanent unconsciousness, with no reasonable expectation of recovery, I direct the withholding or withdrawal of life-sustaining treatment that merely prolongs my dying. I direct that medication and treatment to keep me comfortable and alleviate my pain still be provided.

Artificial Nutrition & Hydration:

_____☑ I DO NOT WANT to receive artificial nutrition and hydration.

Organ and Tissue Donation:

_____☑ I WANT to donate my organs and tissue.

Other Instructions and Wishes: I do not wish to leave other instructions or wishes 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 willingly and free from duress 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:

- 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 willingly and free from duress 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:

- 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: _____