

**LIVING WILL DECLARATION**

If I should be in an incurable or irreversible condition, with no reasonable expectation of recovery, or if there is little likelihood that I will return to a conscious state of self-awareness, I direct all of my health care providers to withhold or withdraw treatments which merely prolong my dying. If my physicians reasonably believe that certain procedures or treatments may lead to recovery, those procedures or treatments may be tried for a period of time, but are to be withdrawn if they do not significantly improve my condition or provide comfort.

Comments: \_\_\_\_\_  
\_\_\_\_\_

I specifically direct that treatments which will keep me comfortable and relieve pain are to be provided.

Comments: \_\_\_\_\_  
\_\_\_\_\_

In addition to comfort measures, I specifically request: \_\_\_\_\_  
\_\_\_\_\_

I especially do not want the following: \_\_\_\_\_  
\_\_\_\_\_

My other instructions and comments are: \_\_\_\_\_  
\_\_\_\_\_

**ORGAN DONATION**

After my death, I wish to donate my organs for use in transplantation.

Limitations: \_\_\_\_\_

**ATTESTATION**

These instructions express my legal right to bodily self-determination. They reflect my firm and settled commitment, made with calm and deliberate resolve. I intend this document to be treated as clear and convincing evidence of my wishes.

\_\_\_\_\_  
Signature Date

**WITNESSES' DECLARATION**

We declare that \_\_\_\_\_ signed this document (or directed another person to sign it) in our presence, willingly and free from duress.

\_\_\_\_\_  
Witness Signature      Witness Signature  
Print name      Print name  
Address      Address

**RE-AFFIRMATION**

I have reviewed and reaffirmed this Proxy and Advance Directive, and I declare that it still expresses my wishes

Initials	Date	Initials	Date
_____	_____	_____	_____
_____	_____	_____	_____

[OPTIONAL. Cross out and initial any sections which do not express your wishes, or make changes as you see fit.]

[You may wish to give special consideration to cardiopulmonary resuscitation (CPR); mechanical breathing devices; artificial feeding or fluids administered through tubes; kidney dialysis; antibiotics; or surgery.]

[OPTIONAL. Cross out and initial if not desired.]

[If you are unable to sign, you may direct another person to sign for you in your presence.]

[This document must be signed in front of two witnesses who are at least 18 years old. **The persons named as Agent or Alternate may not act as witnesses.**]

[OPTIONAL. You may wish to periodically review and initial this document.]



**Albany  
Medical  
Center**

**Health Care  
Proxy  
and  
Living Will**

ALBANY MEDICAL CENTER supports the right of each person to make his or her own medical decisions and is committed to honoring the advance directives of all patients. We encourage you to consider the kinds of care you would want to receive - or would not want to receive - if you were unable to speak for yourself. We also urge you to discuss this with your family or close friends.

New York law allows you to authorize a trusted individual to make medical treatment decisions on your behalf, as your Health Care Agent. You may appoint a Health Care Agent by signing a document called a Health Care Proxy.

Under New York law, you may also express in writing your desire to receive or refuse certain kinds of medical care under various circumstances. A document containing such instructions is known as an Advance Directive or a Living Will. A Living Will does not require the assistance of an attorney, and does not have anything to do with distributing your money or property after death.

You may use this document for both purposes, to appoint an Agent and to express your desires in an Advance Directive.

Cross out and initial any provisions which you do not want, and insert additional statements as you see fit. Please try to be specific. You may want to discuss cardiac resuscitation (CPR), mechanical respiration, or food and fluids administered by tubes (artificial nutrition and hydration)

In order that your wishes will be known and respected, copies of your signed Health Care Proxy and Living Will should be given to your physicians and to close family members or friends. Photocopies are acceptable.

Please review this document from time to time. You may initial and date it to show that it still expresses your intentions, and you may change or revoke it at any time.

Further information, counseling, and additional copies of this form are available from the following Albany Medical Center departments;

Patient Relations 262-3499  
Pastoral Care 262-3176

## Instructions for your Health Care Proxy and Living Will

[The person you choose as your Health Care Agent may be anyone who is at least 18 years old. Your Agent may be a family member or a close friend.]

[OPTIONAL.]

[Under New York law, your Agent may make decisions about artificial nutrition and hydration only if he is aware of your wishes concerning those measures.]

[OPTIONAL.]

[OPTIONAL.]

# Health Care Proxy and Living Will

## APPOINTMENT OF AGENT

I, \_\_\_\_\_, hereby appoint the following person as my Health Care Agent, with authority to make health care decisions for me in the event that I lose the capacity to make those decisions myself:

**Name of Agent** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**Address** \_\_\_\_\_

**Telephone** \_\_\_\_\_

## ALTERNATE AGENT

In the event that the person named above is unable, unwilling, or unavailable to act as my Health Care Agent, I appoint the following person as an Alternate:

**Name of Agent** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**Address** \_\_\_\_\_

**Telephone** \_\_\_\_\_

## AUTHORITY

I direct my Agent to make health care decisions for me, in accordance with my wishes. My wishes may be stated in this document, or my Agent may know them by other means. If my Agent cannot determine my wishes, my Agent is to make decisions in accordance with my best interests. I also direct my Agent to abide by any limitations which are stated in this document or which I otherwise make known to my Agent.

**Limitations:** \_\_\_\_\_

## TERMINATION OF AUTHORITY

I understand that this Proxy will remain in effect indefinitely, unless I revoke it, or until the following date or occurrence:

\_\_\_\_\_  
\_\_\_\_\_