
TO

DURABLE
POWER OF ATTORNEY
New York Statutory Short Form

Dated, _____, ____ 2017

**POWER OF ATTORNEY
NEW YORK STATUTORY SHORT FORM**

(a) CAUTION TO THE PRINCIPAL: Your Power of Attorney is an important document. As the “principal,” you give the person whom you choose (your “agent”) authority to spend your money and sell or dispose of your property during your lifetime without telling you. You do not lose your authority to act even though you have given your agent similar authority.

When your agent exercises this authority, he or she must act according to any instructions you have provided or, where there are no specific instructions, in your best interest. “Important Information for the Agent” at the end of this document describes your agent’s responsibilities.

Your agent can act on your behalf only after signing the Power of Attorney before a notary public.

You can request information from your agent at any time. If you are revoking a prior Power of Attorney, you should provide written notice of the revocation to your prior agent(s) and to any third parties who may have acted upon it, including the financial institutions where your accounts are located.

You can revoke or terminate your Power of Attorney at any time for any reason as long as you are of sound mind. If you are no longer of sound mind, a court can remove an agent for acting improperly.

Your agent cannot make health care decisions for you. You may execute a “Health Care Proxy” to do this.

The law governing Powers of Attorney is contained in the New York General Obligations Law, Article 5, Title 15. This law is available at a law library, or online through the New York State Senate or Assembly websites, www.senate.state.ny.us or www.assembly.state.ny.us.

If there is anything about this document that you do not understand, you should ask a lawyer of your own choosing to explain it to you.

(b) DESIGNATION OF AGENT(S):

I, _____, **residing at** _____, hereby
Name and address of principal
appoint:

_____, **residing at** _____;
as my agent(s)
Name(s) and address(es) of agent(s)

If you designate more than one agent above, they must act together unless you initial the statement below.

() My agents may act SEPARATELY.

(c) DESIGNATION OF SUCCESSOR AGENT(S): (OPTIONAL)

If any agent designated above is unable or unwilling to serve, I appoint as my successor agent(s):

_____, **residing at** _____
Name(s) and address(es) of successor agent(s)

Successor agents designated above must act together unless you initial the statement below.

() My successor agents may act SEPARATELY.

You may provide for specific succession rules in this section. Insert specific succession provisions here:

(d) This POWER OF ATTORNEY shall not be affected by my subsequent incapacity unless I have stated otherwise below, under "Modifications."

(e) This POWER OF ATTORNEY DOES NOT REVOKE any Powers of Attorney previously executed by me unless I have stated otherwise below, under "Modifications."

If you do NOT intend to revoke your prior Powers of Attorney, and if you have granted the same authority in this Power of Attorney, as you granted to another agent in a prior Power of Attorney, each agent can act separately unless you indicate under "Modifications" that the agents with the same authority are to act together.

(f) GRANT OF AUTHORITY:

To grant your agent some or all of the authority below, either

- (1) Initial the bracket at each authority you grant, or
- (2) Write or type the letters for each authority you grant on the blank line at

(P), and initial the bracket at (P). If you initial (P), you do not need to initial the other lines.

I grant authority to my agent(s) with respect to the following subjects as defined in sections 5-1502A through 5-1502N of the New York General Obligations Law:

- ☐ (A) real estate transactions;
- ☐ (B) chattel and goods transactions;
- ☐ (C) bond, share, and commodity transactions;
- ☐ (D) banking transactions;
- ☐ (E) business operating transactions;
- ☐ (F) insurance transactions;
- ☐ (G) estate transactions;
- ☐ (H) claims and litigation;
- ☐ (I) personal and family maintenance. If you grant your agent this authority, it will allow the agent to make gifts that you customarily have made to individuals, including the agent, and charitable organizations. The total amount of all such gifts in any one calendar year cannot exceed five hundred dollars;
- ☐ (J) benefits from governmental programs or civil or military service;
- ☐ (K) health care billing and payment matters; records, reports, and statements;
- ☐ (L) retirement benefit transactions;
- ☐ (M) tax matters;
- ☐ (N) all other matters;
- ☐ (O) full and unqualified authority to my agent(s) to delegate any or all of the foregoing powers to any person or persons whom my agent(s) shall select;
- ☐ (P) EACH of the matters identified by the following letters: (A) (B) (C) (D) (E) (F) (G) (H) (I) (J) (K) (L) (M) (N) (O).

You need not initial the other lines if you initial line (P).

(g) MODIFICATIONS: (OPTIONAL)

In this section, you may make additional provisions, including language to limit or supplement authority granted to your agent.

However, you cannot use this Modifications section to grant your agent authority to make gifts or changes to interests in your property. If you wish to grant your agent such authority, you MUST complete the Statutory Gifts Rider.

(h) CERTAIN GIFT TRANSACTIONS: STATUTORY GIFTS RIDER (OPTIONAL)

In order to authorize your agent to make gifts in excess of an annual total of \$500 for all gifts described in (I) of the grant of authority section of this document (under personal and family maintenance), you must initial the statement below and execute a Statutory Gifts Rider at the same time as this instrument. Initialing the statement below by itself does not authorize your agent to make gifts. The preparation of the Statutory Gifts Rider should be supervised by a lawyer.

() (SGR) I grant my agent authority to make gifts in accordance with the terms and conditions of the Statutory Gifts Rider that supplements this Statutory Power of Attorney.

(i) DESIGNATION OF MONITOR(S): (OPTIONAL)

If you wish to appoint monitor(s), initial fill in the section below:

() I wish to designate _____, whose address(es) is/(are) _____, as monitor(s). Upon the request of the monitor(s), my agent(s) must provide the monitor(s) with a copy of the power of attorney and a record of all transactions done or made on my behalf. Third parties holding records of such transactions shall provide the records to the monitor(s) upon request.

(j) COMPENSATION OF AGENT(S): (OPTIONAL)

Your agent is entitled to be reimbursed from your assets for reasonable expenses incurred on your behalf. If you ALSO wish your agent(s) to be compensated from your assets for services rendered on your behalf, initial the statement below. If you wish to define "reasonable compensation," you may do so above, under "Modifications".

() My agent(s) shall be entitled to reasonable compensation for services rendered.

(k) ACCEPTANCE BY THIRD PARTIES: I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Power of

Attorney. I understand that any termination of this Power of Attorney, whether the result of my revocation of the Power of Attorney or otherwise, is not effective as to a third party until the third party has actual notice or knowledge of the termination.

(l) TERMINATION: This Power of Attorney continues until I revoke it or it is terminated by my death or other event described in section 5-1511 of the General Obligations Law.

Section 5-1511 of the General Obligations Law describes the manner in which you may revoke your Power of Attorney, and the events which terminate the Power of Attorney.

(m) SIGNATURE AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name on _____ 201_.

PRINCIPAL signs here: ==> _____

STATE OF _____)
)
COUNTY OF _____) SS:

On _____, 201_ before me, the undersigned, a Notary Public in and for said State, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Notary Public

Print Name of Notary

My Commission Expires: _____

(n) IMPORTANT INFORMATION FOR THE AGENT:

When you accept the authority granted under this Power of Attorney, a special legal relationship is created between you and the principal. This relationship imposes on you legal responsibilities that continue until you resign or the Power of Attorney is terminated or revoked. You must:

- (1) act according to any instructions from the principal, or, where there are no instructions, in the principal's best interest;
- (2) avoid conflicts that would impair your ability to act in the principal's best interest;
- (3) keep the principal's property separate and distinct from any assets you own or control, unless otherwise permitted by law;
- (4) keep a record of all receipts, payments, and transactions conducted for the principal; and
- (5) disclose your identity as an agent whenever you act for the principal by writing or printing the principal's name and signing your own name as "agent" in either of the following manners: (Principal's Name) by (Your Signature) as Agent, or (your signature) as Agent for (Principal's Name).

You may not use the principal's assets to benefit yourself or anyone else or make gifts to yourself or anyone else unless the principal has specifically granted you that authority in this document, which is either a Statutory Gifts Rider attached to a Statutory Short Form Power of Attorney or a Non-Statutory Power of Attorney. If you have that authority, you must act according to any instructions of the principal or, where there are no such instructions, in the principal's best interest. You may resign by giving written notice to the principal and to any co-agent, successor agent, monitor if one has been named in this document, or the principal's guardian if one has been appointed. If there is anything about this document or your responsibilities that you do not understand, you should seek legal advice.

Liability of agent:

The meaning of the authority given to you is defined in New York's General Obligations Law, Article 5, Title 15. If it is found that you have violated the law or acted outside the authority granted to you in the Power of Attorney, you may be liable under the law for your violation.

(o) AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT: It is not required that the principal and the agent(s) sign at the same time, nor that multiple agents sign at the same time.

I/we, _____ have read the foregoing Power of Attorney. I am/we are the person(s) identified therein as agent(s) for the principal named therein.

I/we acknowledge my/our legal responsibilities.

Agent(s) sign(s) here:==> _____

STATE OF _____)
) SS:
COUNTY OF _____)

On _____, 201_ before me, the undersigned, a Notary Public in and for said State, personally appeared _____ personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that she/he executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Notary Public

Print Name of Notary

My Commission Expires: _____

(p) SUCCESSOR AGENT'S SIGNATURE AND ACKNOWLEDGMENT OF APPOINTMENT:

It is not required that the principal and the SUCCESSOR agent(s) , if any, sign at the same time, nor that multiple SUCCESSOR agents sign at the same time. Furthermore, successor agents can not use this power of attorney unless the agent(s) designated above is/are unable or unwilling to serve.

I/we, _____ have read the foregoing Power of Attorney. I am/we are the person (s) identified therein as Successor Agent (s) for the principal named therein.

Successor Agent(s) sign(s) here:==> _____

(acknowledgment (s))

STATE OF _____)
) SS:
COUNTY OF _____)

On _____, 201__ before me, the undersigned, a Notary Public in and for said State, personally appeared _____ personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that she/he executed the same in her/his capacity, and that by her/his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Notary Public

Print Name of Notary

My Commission Expires: _____

POWER OF ATTORNEY

NEW YORK STATUTORY GIFTS RIDER

AUTHORIZATION FOR CERTAIN GIFT TRANSACTIONS

CAUTION TO THE PRINCIPAL: This **OPTIONAL** rider allows you to authorize your agent to make gifts in excess of an annual total of \$500 for all gifts described in (I) or the Grant of Authority section of the statutory short form Power of Attorney (under personal and family maintenance), or certain other gift transactions during your lifetime. You do not have to execute this rider if you only want your agent to make gifts described in (I) of the Grant of Authority section of the statutory short form Power of Attorney and you initialed "(I)" on that section of that form. Granting any of the following authority to your agent gives your agent the authority to take actions which could significantly reduce your property or change how your property is distributed at your death. "Certain gift transactions" are described in section 5-1514 of the General Obligations Law. This Gifts Rider does not require your agent to exercise granted authority, but when he or she exercises this authority, he or she must act according to any instructions you provide, or otherwise in your best interest.

This Gifts Rider and the Power of Attorney it supplements must be read together as a single instrument.

Before signing this document authorizing your agent to make gifts, you should seek legal advice to ensure that your intentions are clearly and properly expressed.

(a) GRANT OF LIMITED AUTHORITY TO MAKE GIFTS

Granting gifting authority to your agent gives your agent the authority to take actions which could significantly reduce your property.

If you wish to allow your agent to make gifts to himself or herself, you must separately grant that authority in subdivision (c) below.

To grant your agent the gifting authority provided below, initial the bracket to the left of the authority.

() I grant authority to my agent to make gifts to my spouse, children and more remote descendants, and parents, not to exceed, for each donee, the annual federal gift tax exclusion amount pursuant to the Internal Revenue Code. For gifts to my children and more remote descendants, and parents, the maximum amount of the gift to each donee shall not exceed twice the gift tax exclusion amount, if my spouse agrees to split gift treatment pursuant to the Internal Revenue Code.

This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

(b) MODIFICATIONS:

Use this section if you wish to authorize gifts in amounts smaller than the gift tax exclusion amount, in amounts in excess of the gift tax exclusion amount, gifts to other beneficiaries, or other gift transactions. Granting such authority to your agent gives your agent the authority to take actions which could significantly reduce your property and/or change how your property is distributed at your death. If you wish to authorize your agent to make gifts to herself, you must separately grant that authority in subdivision (c) below.

() I grant the following authority to my agent to make gifts pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest:

(c) GRANT OF SPECIFIC AUTHORITY FOR AN AGENT TO MAKE GIFTS TO HIMSELF OR HERSELF: (OPTIONAL)

If you wish to authorize your agent to make gifts to himself or herself, you must grant that authority in this section, indicating to which agent(s) the authorization is granted, and any limitations and guidelines.

() I grant specific authority for the following agent(s) to make the following gifts to himself or herself:

_____, may make gifts to herself as provided above in any amount each year even if the amount of such gifts exceeds the gift tax annual exclusion in effect for that year.

This authority must be exercised pursuant to my instructions, or otherwise for purposes which the agent reasonably deems to be in my best interest.

(d) ACCEPTANCE BY THIRD PARTIES: I agree to indemnify the third party for any claims that may arise against the third party because of reliance on this Statutory Gifts Rider.

(e) SIGNATURE OF PRINCIPAL AND ACKNOWLEDGMENT:

In Witness Whereof I have hereunto signed my name on _____, 201__.

PRINCIPAL signs here: _____

STATE OF NEW YORK)
) SS:
COUNTY OF)

On _____, 201_ before me, the undersigned, a Notary Public in and for said State, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument and acknowledged to me that she/he executed the same in her/his capacity, and that by her/his signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Notary Public

Print Name of Notary

My Commission Expires: _____

(f) SIGNATURES OF WITNESSES:

By signing as a witness, I acknowledge that the principal signed the Statutory Gifts Rider in my presence and the presence of the other witness, or that the principal acknowledged to me that the principal's signature was affixed by him or her or at his or her direction. I also acknowledge that the principal has stated that this Statutory Gifts Rider reflects his or her wishes and that he or she has signed it voluntarily. I am not named herein as a permissible recipient of gifts.

Signature of witness 1

Signature of witness 2

Date

Date

Print name

Print name

Address

Address

City, State, Zip Code

City, State, Zip Code

(g) This document prepared by: _____

Instructions for Execution of New York Short Form Power of Attorney

(a) To be valid, a New York Power of Attorney must be in type of no less than 12 point in size. Please make sure it is or it will not be valid. See NY GOB Law section 5-1501B(1)a.

(b) The New York Statutory Short Form Power of Attorney this system has prepared is exactly as it appears in the New York General Obligations Law section 5-1513(1). There are certain inconsistencies in that form, including capitalization of letters, use of colons, and failure to provide a place for the agent or agents to date the execution by the agent or agents which is a requirement for the form to be valid. However, it is suggested you NOT make changes to eliminate those inconsistencies as that may give third parties grounds to fail to honor the form. One commercial form, for example, uses solid typing (i.e. ALL CAPITAL LETTERS) where the form in the statute does not. This power of attorney will not become effective before both the principal and ALL agents execute it.

(c) Do not execute counterparts as a subsequently executed counterpart may revoke the first executed counterparts unless you have specified under "Modifications" that no previously executed counterpart of this power of attorney is to be revoked by the execution of this power of attorney.

(d) The principal must sign and date the power of attorney and it must be acknowledged before a notary public in the manner prescribed for an acknowledgement of a conveyance of real property.

(e) Each person named as an agent (attorney-in-fact) must also sign and date the power of attorney and it must be acknowledged before a notary public in the manner prescribed for an acknowledgement of a conveyance of real property. This does not apply to any person named as a successor agent but only to the person or persons named as initial agents. NOTE THAT THE SHORT FORM POWER OF ATTORNEY DOES NOT SPECIFY WHERE THE AGENT WILL DATE THE FORM. HENCE, THE AGENT SHOULD WRITE IN THE DATE TO THE RIGHT OF WHERE HE OR SHE SIGNS. THIS SHOULD BE DONE FOR EACH AGENT SIGNING THE POWER OF ATTORNEY.

(f) Make certain the principal initials in his or her own hand in the space provided next to the powers the principal is granting to the agents.

(g) The principal must also initial in the appropriate space provided if he or she wishes the agents and/or successor agents to act separately.

(h) If the principal desires that his or her agent or agents be entitled to reasonable compensation for services rendered, the principal must initial in the appropriate space provided.

(i) If the principal is granting gift giving authority (in addition to the authority to make gifts the principal has customarily made to individuals and charities prior to the execution of the power of attorney none of which may exceed \$500 in any calendar year), the principal must first initial on the Power of Attorney itself the box for "(SGR)" and then SIMULTANEOUSLY execute a Statutory Gifts Rider.

(j) If the principal is simultaneously executing a Statutory Gifts Rider, he or she must execute that form and it must be BOTH witnessed AND acknowledged before the notary public. Note that the agent is not required to sign the Statutory Gifts Rider.

Health Care Proxy

Appointing Your Health Care Agent in New York State

The New York Health Care Proxy Law allows you to appoint someone you trust — for example, a family member or close friend — to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. You may give the person you select as your health care agent as little or as much authority as you want. You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

About the Health Care Proxy Form

This is an important legal document. Before signing, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
3. Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
4. You may write on this form examples of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
5. You do not need a lawyer to fill out this form.
6. You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
7. Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.
8. If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse can no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
9. Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object, nor will your agent have any power to object.
10. You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
11. Appointing a health care agent is voluntary. No one can require you to appoint one.
12. You may express your wishes or instructions regarding organ and/or tissue donation on this form.

Frequently Asked Questions

Why should I choose a health care agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. Appointing an agent lets you control your medical treatment by:

- allowing your agent to make health care decisions on your behalf as you would want them decided;
- choosing one person to make health care decisions because you think that person would make the best decisions;
- choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who can be a health care agent?

Anyone 18 years of age or older can be a health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How do I appoint a health care agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you don't have to use this form.

When would my health care agent begin to make health care decisions for me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accordance with your wishes and interests. However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written. The Health Care Proxy form does not give your agent the power to make non-health care decisions for you, such as financial decisions.

Why do I need to appoint a health care agent if I'm young and healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How will my health care agent make decisions?

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

How will my health care agent know my wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to carry out your interests. If

Frequently Asked Questions, *continued*

agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- whether you would want life support initiated/continued/removed if you are in a permanent coma;
- whether you would want treatments initiated/continued/removed if you have a terminal illness;
- whether you would want artificial nutrition and hydration initiated/withheld or continued or withdrawn and under what types of circumstances.

Can my health care agent overrule my wishes or prior treatment instructions?

No. Your agent is obligated to make decisions based on your wishes. If you clearly expressed particular wishes, or gave particular treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay attention to my agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment) they must tell you or your agent BEFORE or upon admission, if reasonably possible.

What if my health care agent is not available when decisions must be made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions

What if I change my mind?

It is easy to cancel your Health Care Proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Is a Health Care Proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, a Health Care Proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where should I keep my Health Care Proxy form after it is signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or

Frequently Asked Questions, *continued*

deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery.

May I use the Health Care Proxy form to express my wishes about organ and/or tissue donation?

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form and be sure to have the section witnessed by two people. You may specify that your organs and/or tissues be used for transplantation, research or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy.

Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.

Can my health care agent make decisions for me about organ and/or tissue donation?

Yes. As of August 26, 2009, your health care agent is authorized to make decisions after your death, but only those regarding organ and/or tissue donation. Your health care agent must make such decisions as noted on your Health Care Proxy form.

Who can consent to a donation if I choose not to state my wishes at this time?

It is important to note your wishes about organ and/or tissue donation to your health care agent, the person designated as your decedent's agent, if one has been appointed, and your family members. New York Law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf. They are listed in order of priority: your health care agent; your decedent's agent; your spouse, if you are not legally separated, or your domestic partner; a son or daughter 18 years of age or older; either of your parents; a brother or sister 18 years of age or older; or a guardian appointed by a court prior to the donor's death.

Health Care Proxy Form Instructions

Item (1)

Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: *I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.*

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and

I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)

You may state wishes or instructions about organ and/or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse, if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

Item (7)

Two witnesses 18 years of age or older must sign

Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint _____
(name, home address and telephone number)

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: _____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: _____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____ Date _____

Name of Witness 1
(print) _____ Name of Witness 2
(print) _____

Signature _____ Signature _____

Address _____ Address _____

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____ Include: (Indicate by Initialing)

_____ **Alcohol/Drug Treatment**_____ **Mental Health Information**_____ **HIV-Related Information****Authorization to Discuss Health Information**

(b) ☐ By initialing here _____ I authorize _____
Initials Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:

- ☐ At request of individual
- ☐ Other:

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Instructions for the Use
of the HIPAA-compliant Authorization Form to
Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

HEALTH CARE DECLARATION

(Living Will)

Know all people by these presents that I, _____, residing at _____, hereby declare my will with respect to my medical care and treatment in the event I am unable for any reason to make my wishes known at the time medical decisions must be made.

1. Directive to forego or discontinue life-prolonging medical treatment when recovery is unlikely.

In the event I suffer from an injury, disease or illness which renders me unable to make health care decisions on my own behalf, which leaves me unable to communicate with others meaningfully, and from which there is no reasonable prospect of recovery to a cognitive and sentient life (even if my condition or illness is not deemed to be "terminal" and even if my death is not imminent), I direct that no medical treatments or procedures (except as provided in paragraph 4 below) be utilized in my care or, if begun, that they be discontinued.

2. Definition of medical treatment.

By "medical treatments or procedures," I mean interventions by medical doctors, nurses, paramedics, hospitals, residential health care facilities (as defined by subparagraph 3 of Section 2801 of the Public Health Law of the State of New York), or any other health care provider, (as defined by subparagraph 7 of Section 2980 of the Public Health Law of the State of New York), in the care of my body and mind, including all medical and surgical procedures, mechanical or otherwise, treatments, therapies, including drugs and hormones, which may substitute for, replace, supplant, enhance or assist any bodily function. This specifically includes maintenance of respiration, nutrition and hydration by artificial means. With respect to all medical treatments or procedures, I include both existing technology and any methods or techniques which may be hereafter developed and perfected.

3. Guidance for my health care agent and others

I emphasize that this directive to forego or discontinue treatment is to be applied when there is no reasonable prospect of recovery to a cognitive life where I can recognize and interact with my loved ones, but that I wish the medical treatments described above to be attempted if there is a reasonable possibility of such recovery in the opinion of my treating physicians. I understand that in such case treatments may be instituted although later withdrawn if such recovery does not occur.

4. Provision for pain control.

I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible.

5. Determination of prognosis.

My Health Care Agent acting pursuant to my duly executed Health Care Proxy shall follow my directions as set out in this Health Care Declaration whenever my Agent has ascertained by applying reasonable medical standards that my condition is as described in Section 1, above. In the absence of the instructions of my agent, any persons or institutions who are called upon to make decisions affecting my care shall comply with my directions contained herein. In the event of uncertainty or ambiguity as to how my wishes are to be interpreted or applied in any particular situation, any persons or institutions who are treating me shall comply with the interpretations and directions of my Health Care Agent.

6. Desire to remain at home.

In the event I require long term medical treatment and care, I hereby express my desire to remain at home for as long as is appropriate and not be institutionalized. My wishes and directions shall be followed whether I am at home, in a hospital or in a residential health care facility.

7. Acknowledgement of effects of this Declaration.

I make and execute this Declaration knowing that, if complied with, my death may occur sooner than it would were all available and appropriate medical treatments considered and used. I accept this as a necessary result of a decision to avoid dependence and pain. And I make the decision now, for myself, after careful consideration, to assure that I will have the level of medical care which I want, to guide my health care agent, and to relieve others of the burden of decision.

Dated: _____, 201__

Statement by Witness (*Witness must be 18 years of age or older and cannot be the health care agent or alternate*).

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date: _____

Name of Witness I

Signature _____

Address

Date: _____

Name of Witness 2

Signature _____

Address

APPOINTMENT OF AGENT TO CONTROL DISPOSITION OF REMAINS

I, _____ residing at _____
(your name and address)

being of sound mind, willfully and voluntarily make known my desire that, upon my death, the disposition of my remains shall be controlled by _____
(name of agent)

With respect to that subject only, I hereby appoint such person as my agent with respect to the disposition of my remains.

SPECIAL DIRECTIONS:

Set forth below are any special directions limiting the power granted to my agent as well as any instructions or wishes desired to be followed in the disposition of my remains:

Indicate below if you have entered into a pre-funded pre-need agreement subject to section four hundred fifty-three of the general business law for funeral merchandise or service in advance of need:

☐ No, I have not entered into a pre-funded pre-need agreement subject to section four hundred fifty-three of the general business law.

☐ Yes, I have entered into a pre-funded pre-need agreement subject to section four hundred fifty-three of the general business law.

(Name of funeral firm with which you entered into a pre-funded pre-need funeral agreement to provide merchandise and/or services)

AGENT:

Name: _____

Address: _____

Telephone Number: _____

SUCCESSORS:

If my agent dies, resigns, or is unable to act, I hereby appoint the following persons (each to act alone and successively, in the order named) to serve as my agent to control the disposition of my remains as authorized by this document:

1. First Successor

Name: _____

Address: _____

Telephone Number: _____

2. Second Successor

Name: _____

Address: _____

Telephone Number: _____

DURATION:

This appointment becomes effective upon my death.

PRIOR APPOINTMENT REVOKED:

I hereby revoke any prior appointment of any person to control the disposition of my remains.

Signed this _____ day of _____, 2017.

(Signature of person making the appointment)

Statement by witness (must be 18 or older)

I declare that the person who executed this document is personally known to me and appears to be of sound mind and acting of his or her free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1: _____ (signature)

Address: _____

Witness 2: _____ (signature)

Address: _____

ACCEPTANCE AND ASSUMPTION BY AGENT:

1. I have no reason to believe there has been a revocation of this appointment to control disposition of remains.

2. I hereby accept this appointment.

Signed this _____ day of _____, 2017.

(Signature of agent)