HOMETOWN HEALTH CENTERS – PATIENT REGISTRATION

Patient Name: _____

Address: _____ ☐ Homeless

City: _____ State: _____ Zip Code: _____

Home #:_____ Cell #:_____ Work #:_____ SS#: _____ Sex: M____ F ____

May we leave a message? (check box for yes) ☐ Home phone ☐ Cell phone ☐ Work phone

Date of Birth:_____ E mail:_____ @ _____

(For reporting purposes only)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Pacific Islander ☐ Multi-race ☐ Native American ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to report

Primary Language: ☐ English ☐ Spanish Other:_____

Military Status: Are you a veteran? Yes ☐ No ☐

HEAD OF HOUSEHOLD/PERSON RESPONSIBLE FOR THIS ACCOUNT

(IF DIFFERENT FROM ABOVE)

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____SS#: _____ Sex: M___ F ___ Date of Birth_____ Relationship:_____

HOUSEHOLD INFORMATION

As a Federally Qualified Health Care Center, we need the following information for statistical reports

Approximate Annual Family Income:$ _____ Number of Family Members: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone _____

Address: _____ Relationship _____

PHARMACY INFORMATION

Name of Pharmacy:_____ Phone number:_____

Address/location: _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I Authorize Hometown Health Centers to release any information, including diagnosis and the records of any treatment or examination rendered to me (or my child) during the period of such care, to third party payers and/or health practitioners. I authorize and request my insurance company to pay, directly to Hometown Health Centers, group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I hereby, certify that to the best of my knowledge all of the above information is true and correct. I understand that program officials may verify information on this form or use information for statistical analysis. I also understand that information I supply will be kept confidential.

Payment is expected at the time of service unless other arrangements have been made. We accept cash, checks, and credit cards.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Signature of HHC Staff Date

Hometown Health Centers

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

- I authorize Hometown Health Centers to release information, including diagnosis and the records of any treatment rendered to me (or my child) during the period of such care to third party payers and/or health practitioners.
- I authorize my insurance company to pay Hometown Health Centers directly all insurance benefits. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents that is not covered by insurance.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I acknowledge that I have received a copy of Hometown Health Centers' Notice of Privacy Practices. This notice describes how Hometown Health Centers may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

RELEASE OF INFORMATION

- We participate in (i) the Alliance for Better Health Care, LLC, a Performing Provider System (PPS) and/or (ii) the Innovative Health Alliance of New York, LLC, an Accountable Care Organization (ACO) and/or (iii) the Innovative Health Alliance of New York, IPA, LLC. These are NYS regulated programs created to coordinate your care and to reduce unnecessary or duplicate medical procedures or tests. By signing this form, you allow us to share your health information with other health care providers who are treating you and who participate in the PPS or ACO, in order to coordinate your care. Note that the health information you are allowing us to share may include HIV/AIDS information, mental health conditions, and/or information about sexually transmitted diseases.

ACKNOWLEDGEMENT OF RECEIPT OF HANDBOOK FOR ADVANCE DIRECTIVES

- I acknowledge that I have received a copy of "Planning Your Health Care in Advance" New York State's Booklet on Advance Directives and Health Care Proxy Form.

GENERAL CONSENT FOR ELECTRONIC PRESCRIBING

- I give my permission for Hometown Health Centers to electronically prescribe medication on my behalf to the pharmacy of my choice and to access my electronic prescription information and history.

GENERAL CONSENT FOR TELEHEALTH TREATMENT

- I hereby authorize and request providers used by Hometown Health Centers via telehealth services to provide appropriate treatment for:

***>> CONSENT CONTINUED ON BACK << ***

CONTINUATION OF CONSENT…

GENERAL CONSENT FOR TREATMENT

- I hereby authorize and request Providers at Hometown Health Centers to provide appropriate treatment for:

_____ _____

Patient Name **Patient Date of Birth**

_____ _____

Signature of Patient, Parent/Guardian, Legal Representative **Date**

_____ _____

Print Name **Relationship to Patient**

Witness/Hometown Health Centers Employee: _____

Date: _____

Hixny ELECTRONIC DATA ACCESS CONSENT FORM
HOMETOWN HEALTH CENTERS

In this Consent Form, you can choose whether to allow **HOMETOWN HEALTH CENTERS** to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (Hixny), doing business as Hixny, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow **HOMETOWN HEALTH CENTERS** to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, **HOMETOWN HEALTH CENTERS** staff involved in my care may see and get access to all of my medical records through Hixny."

If you check the **"I DENY CONSENT"** box below, you are saying "No, **HOMETOWN HEALTH CENTERS** may not be given access to my medical records through Hixny for any purpose."

Hixny is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about Hixny and ehealth in New York State, read the brochure, "Your Health Information – Always at Your Doctor's Fingertips." You can ask **HOMETOWN HEALTH CENTERS** for it, or go to the website www.hixny.org.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices.

☐ **I GIVE CONSENT for HOMETOWN HEALTH CENTERS to access ALL of** my electronic health information through Hixny in connection with providing me any health care services, including emergency care.

☐ **I DENY CONSENT for HOMETOWN HEALTH CENTERS to access** my electronic health information through Hixny for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through Hixny.

_____	_____
Print Name of Patient	Patient Date of Birth
_____	_____
Signature of Patient or Patient's Legal Representative	Date
_____	_____
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about patient information in Hixny and the consent process:

1. How Your Information Will be Used. Your electronic health information will be used by **HOMETOWN HEALTH CENTERS** to:
• Provide you with medical treatment and related services
• Check whether you have health insurance and what it covers
• Evaluate and improve the quality of medical care provided to all patients.
NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. What Types of Information about You Are Included. If you give consent, **HOMETOWN HEALTH CENTERS** may access ALL of your electronic health information available through Hixny. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:
• Alcohol or drug use problems
• Birth control and abortion (family planning)
• Genetic (inherited) diseases or tests
• HIV/AIDS
• Mental health conditions
• Sexually transmitted diseases

3. Where Health Information About You Comes From. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from **HOMETOWN HEALTH CENTERS**. You can obtain an updated list of Information Sources at any time by checking the Hixny website: www.hixny.org.

4. Who May Access Information About You, If You Give Consent. Only these people may access information about you: doctors and other health care providers who serve on **HOMETOWN HEALTH CENTERS** medical staff who are involved in your medical care; health care providers who are covering or on call for **HOMETOWN HEALTH CENTERS** doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call **HOMETOWN HEALTH CENTERS** at (518) 370-1441 or call Hixny at (518) 783-0518; or call the NYS Department of Health at (877) 690-2211.

6. Re-disclosure of Information. Any electronic health information about you may be re-disclosed by **HOMETOWN HEALTH CENTERS** to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. Hixny and persons who access this information through the Hixny must comply with these requirements.

7. Effective Period. This Consent Form will remain in effect until the day you withdraw your consent or until such time Hixny ceases operation.

8. Withdrawing Your Consent. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to **HOMETOWN HEALTH CENTERS**. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any Hixny provider, from the Hixny website at www.hixny.org, or by calling (518) 783-0518. **Note: Organizations that access your health information through Hixny while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.**

9. Copy of Form. You are entitled to get a copy of this Consent Form after you sign it**.**

Hometown Health Centers

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Thank you for choosing Hometown Health Centers for your healthcare needs. We are privileged to have your confidence and are committed to safeguarding the personal information that you give/have given us. This notice will explain our policy of collecting, handling, using and securing individually identifiable patient information as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I. PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION

TREATMENT, PAYMENT, HEALTHCARE OPERATIONS: You should be aware that during the course of our relationship with you that we likely will use and disclose health information about you for treatment, payment and healthcare operations. Examples of these activities are as follows:

Treatment: Your confidential healthcare information may be released to other healthcare professionals for the purpose of providing you with quality healthcare.

Payment: Your confidential healthcare information may be released to your insurance provider for the purpose of the health center receiving payment for providing you with needed healthcare services.

Healthcare Operations: Your confidential healthcare information may be disclosed in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, our review of the ability or qualifications of our healthcare professionals, evaluating practitioner and provider performance and other SFHS business operations.

AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone. We will do so upon our receipt of a written authorization from you stating that we may use or disclose your health information in agreement with that authorization. You may cancel any such authorization at any time by notifying us in writing. This cancellation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this notice or as otherwise permitted by law.

DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose our health information to you as described below in the Patient Rights section of this Notice. Note that such disclosures will be made to any of your personal representatives (parent, child, husband or wife, etc.) appropriately authorized by you to provide them access and/or control of your health information. Under certain circumstances, including emergency treatment, we may disclose your location and general condition to a family member, other relative, close personal friend or any other person who you identify. We also may disclose health information related to such an individual's involvement in your care or with payment related to your care.

MARKETING: We will not use your health information for marketing communications without your written authorization. We will not sell your health information to anyone.

USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g. disease reporting). In some instances, and in agreement with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to avoid a serious threat to your health or safety or to the health or safety of others.

LAW ENFORCEMENT / NATIONAL SECURITY: We may disclose health information in response to properly issued subpoenas, judicial proceedings and law enforcement inquires as permitted by law. Under certain circumstances we may disclose health information relating to members of the Armed Forces, to military authorities and to authorized federal officials if such information is required for lawful intelligence, counterintelligence and other national security activities. Under certain circumstances we also may disclose health information relation to inmates or patients to correctional institutions or to law enforcement personnel having lawful custody of those individuals.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

FOOD AND DRUG ADMINISTRATION ("FDA"): We may disclose to the FDA health information relative to unfavorable events with respect to food, supplements, products and product defects or post marketing study information to enable product recalls, repairs or replacement.

WORKER'S COMPENSATION: We may disclose health information to the extent authorized by laws relation to workers' compensation or to other similar programs established by law.

FUNDRAISING: You may be contacted by the health center for the purposes of raising funds to support the health center's operation. You will be given the opportunity to opt out of any future fundraising contacts.

BUSINESS ASSOCIATES: There are some services provided in SFHS through contracts with our business associates. Examples include contracted physician services in certain specialty departments and laboratory tests. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your insurance company for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

II. PATIENT RIGHTS:

ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. If you request copies we will charge you a reasonable copying fee. If you request that the records be mailed, we may charge you for postage. If you prefer, we will prepare a summary of an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

You may request that we provide copies in a non-photocopy format, and we will supply records in that format if it is readily available. If you request records in an alternative format, we will charge a reasonable fee for providing your health information in that format.

ACCOUNTING OF CERTAIN DISCLOSURES: Upon written request, you have the right to receive a list of instances in which we or our business associate disclosed your health information for purpose other than treatment, payment, healthcare operations and other activities authorized by you for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a twelve (12)-month period, we may charge you a reasonable fee for responding to these additional requests.

RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and health-care operation purposes. Depending on the circumstance of your request we may, or may not, agree to those restrictions. If we do agree to your requested restrictions, we must honor them except in emergency treatment situations. You have the right to request that we communicate with you about your health information by other means or to another location (e.g. at your place of business rather than at your home). Such requests must be made in writing, must specify the other means or location and must provide satisfactory explanation how payments will be handled under the other means or location you request.

AMENDMENTS TO RECORDS: We make every effort to maintain complete, accurate and up-to-date information about you and about your health status. If you believe that our information is incomplete or incorrect, you have the right to request that we make changes to your health information. Such requests must be made in writing and must explain why the information should be changed. We may deny your request under certain circumstances. If you wish to make a change, please contact our Health Information Manager at (518) 370-1441.

III. PROTECTION OF YOUR INFORMATION:

We maintain security over your personal information through a combination of physical, electronic and procedural means as well as contractual agreements. Through procedures and security levels, we limit access to patient information to only those employees and others who must use it in order to properly serve your healthcare needs.

IV. EFFECTIVE DATE AND CHANGES TO NOTICE:

We are required to provide you with this notice and to follow the privacy practices described above while this Notice is in effect. This Notice is effective as of April 14, 2003, and will remain in effect until we replace it. We reserve the right to change this Notice and the privacy practice described at any time in accordance with applicable law. Before making significant changes to our privacy practices, we will alter this Notice to reflect the changes and make the revised Notice available to you upon your request. Any changes we make to our privacy practices and/or to this Notice may apply to health information created or received by us before the date of the changes.

V. QUESTIONS AND COMPLAINTS

If you want more information about our privacy practice or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights of if you disagree with a decision that we made or any decisions that we may make regarding the use, disclosure or access to your health information, you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Privacy Officer
1044 State Street
Schenectady NY, 12307
Telephone: (518) 370-1441
Fax: (518) 395-9431

Hometown
Health
Centers

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. However, in New York State, only a health care agent you appoint has the legal authority to make treatment decisions if you are unable to decide for yourself. 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 serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care

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 you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

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 purse or with other important papers, but not in a location where no one can access it, like a safe

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?

No. The power of a health care agent to make health care decisions on your behalf ends upon your death. Noting your wishes on your Health Care Proxy form allows you to clearly state your wishes about organ and tissue donation

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 so that family members who will be approached about donation are aware of your wishes. However, 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 spouse, 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, or any other legally authorized person.

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 there is no hope that my condition will improve, I do/don't want the following types of treatments:....

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. A health care agent cannot make a decision about organ and/or tissue donation because the agent's authority ends upon your death. The law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your spouse, 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, or any other legally authorized person.

Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

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 know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(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 _____

_____ _____

State of New York
Department of Health