F00190

ROSWELL PARK
CANCER INSTITUTE
ELM & CARLTON STREETS
BUFFALO, NY 14263

Health Care Proxy

1. I choose _____,
NAME OF HEALTH CARE AGENT HOME ADDRESS TELEPHONE NUMBER

to be my Health Care Agent to make health care decisions for me, if I become unable to make my own health care decisions.

2. **OPTIONAL: ALTERNATE AGENT:** If the person named above is unable, unwilling or unavailable to act as my health care agent, I choose:

_____
NAME OF ALTERNATE AGENT HOME ADDRESS TELEPHONE NUMBER

3. Unless I revoke or cancel this proxy, it shall remain in effect indefinitely.

4. I direct my health care agent to make health care decisions according to my wishes and/or as stated below. My agent knows my wishes, including those about artificial nutrition and hydration [*nourishment and water provided by feeding tube and intravenous line*], or my wishes are described below.

_____

_____

5. **OPTIONAL: ORGAN AND /OR TISSUE DONATION:**

❑ I hereby, make an anatomical gift, to be effective upon my death, of:
- ❑ Any needed organs
- ❑ The Following organs and/or tissues:_____
- ❑ Limitations _____

❑ I do not want to state my wishes about organ and/or tissue donation at this time.

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

6. **My Signature:** _____ **Date:** _____

My Name *(please print)***:** _____

My Address:_____

7. **TWO WITNESSES: (WITNESSES MUST BE 18 OR OLDER AND CANNOT BE THE HEALTH CARE AGENT OR ALTERNATE AGENT)**
I declare that the person who signed this document is personally known to me and appears to be 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.

Witness #1: _____ Witness #2:_____

Address: _____ Address: _____

Original - Patient *Copy - Medical Records* *Copy - Registration*