ColumbiaDoctors

New Patient Intake Form

Do NOT complete this page if you have previously provided this information to ColumbiaDoctors.

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: ____/____/____ Gender: _____

Home Address: _____ City, ST: _____ Zip: _____

Home Phone: _____ Other Phone: _____ Preferred: Home Other

Patient Email Address: _____ Marital Status: _____

Guarantor/Parent: _____ Date of Birth: ____/____/____

Address: _____ City, ST: _____ Zip: _____

Phone: _____ Relationship to Patient: _____

Emergency Contact (if other than guarantor): _____

Emergency Phone: _____ Relationship to Patient: _____

Insurance Information

Insurance Company Name: _____

Insurance Address: _____ City, ST: _____ ZIP: _____

Certificate/Plan/ID #: _____ Group (Grp): _____

Subscriber (if other than patient or guarantor): _____

Subscriber Address: _____ City, ST: _____ ZIP: _____

Subscriber Date of Birth: ____/____/____ Relationship to Patient: _____

Please present a copy of your insurance card/information, if available, when you return this form.

Patient Employment Information

Employer: _____ Occupation: _____

Employer Address: _____ City, ST: _____ Zip: _____

Patient Work Phone: _____

Text Messaging Agreement

□ I consent to receive messages from ColumbiaDoctors for my healthcare services at the phone number(s) above, and my wireless (fill in) _____. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

□ Opt out

myColumbiaDoctors Patient Portal Sign Up

Access your personal records securely, 24/7, on a computer, smartphone, or iPad. See brochure for details.

□ Send me an invitation to join myColumbiaDoctors. □ Opt out

Look for your email invite to register from noreply@followmyhealth.org and click the registration link.

ColumbiaDoctors

Last Name: _____ First Name: _____ DOB: / /

Please provide information regarding your health care providers in the spaces below:

	Name	Phone	Location	Date of last visit
Primary Care				/ /
Psychiatrist				/ /
Psychotherapist				/ /
Dentist				/ /

Preferred Pharmacy: _____ Pharmacy Phone: _____

Preferred Pharmacy Address: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- ☐ Decline Response
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race:

- ☐ Decline Response
- ☐ American-Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other

Preferred Language: _____ ☐ Decline Response

Patient Signature: _____ Date: _____

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles may be collected upon check-in for each visit. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient or Guarantor Name (Print): _____

Patient or Guarantor Signature: _____ Date: _____

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

If completed by a patient's personal representative, please print and sign below.

Representative (Print): _____ Relationship: _____

Representative Signature: _____ Date: _____

Name: DOB: ColumbiaDoctors

Reason for today's visit:

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems	☐ Y	☐ N	Heart Disease/Disorder	☐ Y	☐ N
Arthritis	☐ Y	☐ N	Lung Disorder	☐ Y	☐ N
Bleeding/Clotting Disorder	☐ Y	☐ N	Liver Disease	☐ Y	☐ N
Blood Pressure Disorder	☐ Y	☐ N	Neurological Disorder/Chronic Headaches	☐ Y	☐ N
Blood Transfusion	☐ Y	☐ N	Psychiatric Disorder/Illness	☐ Y	☐ N
Bowel/Stomach Problems	☐ Y	☐ N	Pulmonary Embolism/DVT	☐ Y	☐ N
Cancer	☐ Y	☐ N	Stroke	☐ Y	☐ N
Cholesterol Disorder	☐ Y	☐ N	Seizure or Epilepsy	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Thyroid Disorder	☐ Y	☐ N
Eye Disorder (i.e. Glaucoma, cataract)	☐ Y	☐ N	Urinary/Kidney Disorder	☐ Y	☐ N
Women Only: Gynecological Issues	☐ Y	☐ N			

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		☐ Y ☐ N	
Father		☐ Y ☐ N	
Sibling		☐ Y ☐ N	
Other:		☐ Y ☐ N	

Do you currently smoke? ☐ Y ☐ N If no, previously? ☐ Y ☐ N Years smoked _____ Packs/day _____

Do you use other tobacco products? ☐ Y ☐ N Consume alcohol? ☐ Y ☐ N If yes, drinks/week: _____

Women Only: Any past pregnancies? ☐ Y ☐ N How many? ___ How many deliveries? ____

Name: DOB: ColumbiaDoctors

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N
If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction

Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose

Medication Name	Dose

ColumbiaDoctors

Please list ALL previous physicians who have treated you relevant to your visit (i.e. pulmonologist, oncologist, internist, cardiologist, gastroenterologist, etc...)

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Provider Signature: _____ Date: _____

NewYork-Presbyterian
The University Hospital of Columbia and Cornell
43530

Weill Cornell Medicine

ColumbiaDoctors
The Physicians and Surgeons of Columbia University

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

Patient Name (please print):	Maiden or Other Name (please print):	Patient Date of Birth: / /
Patient Address (please print)		
Telephone (Area Code and Number): ( )	Email address (please print):	Medical Record Number:

Name, address and telephone number of Person(s) or Entity to whom this information will be sent. Please check if same as above ☐
Send to (please print):

Address (please print):

Telephone (Area Code and Number): ( )
Fax (Area Code and Number): ( )

Check the name of the Center to disclose information or choose Other Healthcare Provider (specify):
Hospital/Inpatient
☐ NYP/Columbia University Medical Center (NYP/Allen Hospital; NYP/Morgan Stanley Children's Hospital) ☐ NYP/Weill Cornell Medical Center
☐ NYP/Westchester Division ☐ NYP/Lower Manhattan ☐ NYP/Lawrence ☐ NYP/Brooklyn Methodist ☐ NYP/Hudson Valley ☐ NYP/Queens

Outpatient/Physician's Office
☐ Columbia Doctors (outpatient/physician's office record only) please print your physician's name:_____
☐ Weill Cornell Medicine (outpatient/physician's office record only) please print your physician's Name:_____
☐ Other (Please print Name of Entity)_____

Specify information to be released (medical records will not be released unless a date of service(s) is identified on this form):
Medical Record from (insert date)__/__/____ to (insert date) __/__/__
☐ Hospital Admission ☐ Emergency Department ☐ Ambulatory Surgery
☐ Outpatient / Physician's Office Records Only
Specify reports requested (i.e. Lab tests, Radiology Reports, Operative Reports, Discharge Summary, etc.):_____

Note: If you need the Radiology/X-Ray images, please send a copy of this request to Radiology at the facility where the procedure was performed.

Include (Indicate by Initialing below): Please note that the information will not be released if not initialed.
_____ Alcohol/Drug Treatment/Testing
_____ Mental Health Testing/Treatment (except psychotherapy notes)
_____ HIV/AIDS Related Information
_____ Genetic Testing Information

Please consider the environment. When possible, we will provide the information you requested electronically please check preference:
☐ CD ☐ DVD ☐ Flash drive (with restrictions) ☐ Electronic Delivery (to MyChart/myNYP.org portal, if available, appropriate) ☐ E-mail, (not secure)

Patients with an active electronic medical records account (patient portal) can request electronic delivery via secure web patient portal at no cost. Please confirm and initial below:
I have an active patient portal account and understand the medical record(s) I requested will be sent to my patient portal account at: ☐ MyChart/myNYP.org

If my medical record(s) cannot be delivered to my patient portal account it will be mailed to the above-stated address on an encrypted portable media (e.g. CD/DVD, Flash drive [with restrictions], etc.)
Patient or Personal Representative Initial _____

The purpose(s) for which disclosure is authorized (check where applicable): ☐ Individual's request ☐ Medical Care ☐ Insurance ☐ Immunization ☐ Legal
☐ Other (specify): _____ (please print)

I, or my authorized representative, request that health information regarding my care and treatment at NewYork-Presbyterian Hospital (NYP) or Columbia Doctors (CD) or Weill Cornell Medicine (WCM) be disclosed as described on this form. I understand that:

- I may inspect and/or receive a copy of the information described on this Authorization by completing this form and signing below.
- Providers are permitted to charge reasonable fees to recover costs for inspections and/or copying.
- Treatment and payment will not be conditional on whether you sign this authorization. Signing is voluntary, however if you refuse to sign NYP / CD / WCM will not release your records.
- By my specifically authorizing the release of HIV/AIDS related alcohol or drug treatment, or mental health treatment information that the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. 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.
- Alcohol/drug treatment-related information or confidential HIV/AIDS related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.
- I may revoke this authorization at any time by providing written notice to NYP / CD / WCM except to the extent that action has already been taken based on this authorization.

I understand that this Authorization will expire on: Date_____/_____/_____(provide date if less than 1 year) or 1 year after being signed.

Signature of Patient/Personal Representative (e.g. Legal Guardian) _____ Date __/__/__

If Personal Representative, Print Name and Relationship: Name of Personal Representative _____ Relationship _____

Witness/Notary _____

Weill Cornell Medicine | NewYork-Presbyterian | COLUMBIA

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

Weill Cornell Medicine, NewYork-Presbyterian, and Columbia University participate in an Organized Health Care Arrangement (OHCA). This allows us to share health information to carry out treatment, payment and joint health care operations relating to the OHCA, including integrated information system management, health information exchange, financial and billing services, insurance, quality improvement, and risk management activities. Organizations that will follow this notice include Weill Cornell Medicine, NewYork-Presbyterian sites, Columbia University and their entities.

Date: _____

I acknowledge that I was provided with a copy of the Weill Cornell Medicine, NewYork-Presbyterian, and Columbia University Notice of Privacy Practices.

Patient Name (Print): _____

Patient (Signature): _____

If completed by a patient's personal representative (or if the patient is a minor), please print and sign your name in the space below.

Personal Representative/Guardian (Print): _____

Personal Representative/Guardian (Signature): _____

Relationship to the patient: _____

Effective Date: April 2, 2018

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.

Frequently Asked Questions, *continued*

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.

Frequently Asked Questions, *continued*

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 decide in advance 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?
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; a guardian appointed by a court prior to the donor's death; or another person authorized to dispose of the body.

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. 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 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.

Witness 1

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address _____

_____

NEW YORK STATE | Department of Health