

**Sample New York Living Will**  
(aka "Advanced Medical Directive")

[Online Legal Form \\$8.99 \(click here for more information\)](#)

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**ADVANCE MEDICAL DIRECTIVE AND  
HEALTH CARE PROXY  
GIVEN BY  
THOMAS RICHARD JONES**

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**THIS IS AN IMPORTANT LEGAL DOCUMENT. THIS DOCUMENT DIRECTS THE MEDICAL TREATMENT YOU ARE TO RECEIVE IN THE EVENT YOU ARE UNABLE TO PARTICIPATE IN YOUR OWN MEDICAL DECISIONS AND YOU ARE EITHER IN A TERMINALLY ILL CONDITION OR PERSISTENTLY UNCONSCIOUS. THIS DOCUMENT CAN CONTROL WHETHER YOU LIVE OR DIE. PREPARE THIS DOCUMENT CAREFULLY AND READ IT COMPLETELY. PLEASE REVIEW IT PERIODICALLY.**

**Explanation**

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as "proxy" or, as used in this form, agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Your agent may not be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

In Part 1 of this form, the individual named as "health care agent" herein is intended by the declarant to be his or her health care "proxy" under the Consolidated Laws of New York, Public Health, Ch. 45, Article 29-C, Sections 2980 through 2992.

Under this agreement, your agent must follow the directions you give in Part 2 hereof regarding which types of health care treatment are to be withdrawn or withheld under the circumstances stated.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

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## **PART 1 HEALTH CARE PROXY**

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me: **Elise Susan Jones** whose residence is 1123 State Street, Buffalo, NY and whose telephone number is 716-222-8888.

If Elise Susan Jones shall be unable or unwilling to act as my agent for health-care decisions, I designate the following individual to act as my successor agent: **Tim Russert** whose residence is 777 Heavenly Way, Buffalo, NY and whose telephone number is 716-777-0000.

(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me, including those forms of health care necessary to keep me alive. Furthermore, the authority I give my agent shall include decisions to provide, withhold, or withdraw artificial nutrition. The power of my agent granted herein shall not be affected by my subsequent incapacity.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when both (1) my attending physician determines that I am no longer able to understand, appreciate, and direct my medical treatment **and** (2) two physicians--one of whom is my attending physician and the other is qualified and experienced in making such diagnosis--have personally examined me and have diagnosed and documented in my medical records that I am either terminally ill **or** that I am in a state of persistent unconsciousness with no reasonable expectation of recovery.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care and any instructions I give in Part 2 of this form. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

## **PART 2 INSTRUCTIONS FOR HEALTH CARE**

I have the primary right to make my own decisions concerning treatment that might unduly prolong the dying

process. By this declaration, I express to my physician, family and friends my intent.

(6) END-OF-LIFE DECISIONS: In cases where both (1) my attending physician determines that I am no longer able to understand, appreciate, and direct my medical treatment **and** (2) two physicians--one of whom is my attending physician and the other is qualified and experienced in making such diagnosis--have personally examined me and have diagnosed and document in my medical records that I am either terminally ill or that I am in a state of persistent unconsciousness with no reasonable expectation of recovery, I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choices I have stated below. The word "Withhold" shall be used to mean both withholding the treatment if it has not yet been given and withdrawing the treatment if it is currently being administered.

* Artificially supplied nutrition and hydration (including tube feeding or food and water)	<b>Withhold</b>
* Surgery or other invasive procedures (i.e., those where medical instruments must enter the body)	<b>Withhold</b>
* Heart-lung resuscitation (CPR)	<b>Withhold</b>
* Antibiotics	<b>Do NOT Withhold</b>
* Kidney or Renal dialysis	<b>Withhold</b>
* Mechanical ventilator (respirator)	<b>Withhold</b>
* Chemotherapy and other radiation therapy	<b>Withhold</b>
* All other "life sustaining" medical procedures that are merely intended to keep me alive without reasonable hope of improving my condition	<b>Withhold</b>

**I hereby acknowledge the above choices:**

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**Thomas Richard Jones**

Declarant / Principal

(7) RELIEF FROM PAIN: I direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

(8) HIPAA Privacy Authorization. I hereby authorize my Agent to execute any form authorization for use or disclosure of my Protected Health Information relating to past, present or future medical records required by the Health Insurance Portability and Accountability Act ("HIPAA"). My Agent is authorized to execute a HIPAA form authorization for release of my medical records in favor of any health provider or other party that the Agent deems appropriate.

**PART 3  
DONATION OF ORGANS AT DEATH  
(OPTIONAL)**

(9) ORGAN DONATION: I do not wish to authorize donation of my organs.

**PART 4**  
**PRIMARY PHYSICIAN**  
**(OPTIONAL)**

(10) DESIGNATION OF PHYSICIAN: I designate the following physician as my primary physician: Ron Paul, MD.

\* \* \* \* \*

(11) EFFECT OF COPY: A copy of this form has the same effect as the original.

(12) DURABILITY OF HEALTH CARE AGENT'S POWERS: This Health Care Power of Attorney is a durable power of attorney and the authority of my agent shall not terminate if I become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive. If I have also executed a durable financial power of attorney, this document is not meant to override that document. My health care agent's powers only extend to health care decisions as outlined in this document.

(13) DEFINITIONS:

"Artificially Provided Nutrition and Hydration" means feeding a patient through a means that is not natural such as (1) intravenously (i.e., inserting a needle directly into a patient's veins through which food or water would be forced into the patient's blood stream) or (2) a feeding tube inserted in the nose or mouth through which food or water would be forced into an individual's stomach. Assisted feeding, such as by a spoon or bottle, where the patient actively participates in the feeding process by chewing or swallowing is not considered "artificially provided nutrition and hydration".

"Persistently Unconscious" means a condition that, to a reasonable degree of medical certainty: (a) will last permanently without improvement, (b) one in which cognitive thought, purposeful action, and awareness of self and environment are absent, and (c) which has existed for a period of time sufficient, in accordance with applicable medical standards, to make a diagnosis called for in parts (a) and (b) hereof.

"Terminally Ill" means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, to a reasonable degree of medical certainty, result in death within a relatively short time.

"Life-Sustaining Treatment" means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to the patient, would serve only to prolong the dying process where the patient has a terminal illness or injury, or would serve only to maintain the patient in a condition of permanent unconsciousness. These procedures shall include, but are not limited to, surgery, chemotherapy, CPR, dialysis, use of mechanical respirators, blood transfusions, and the administration of all drugs and antibiotics (except those intended to ease pain).



(Note: This page is **not** to be attached to your Health Care Directive.)

## **INSTRUCTIONS REGARDING EXECUTION OF YOUR HEALTH CARE DIRECTIVE AND MEDICAL POWER OF ATTORNEY**

- A. Please remember to fill in your social security number below your name on the signature page.
- B. **Please note that the principal's signature is required on pages 3 and 5 of this document.**
- C. **Special Note for New York Living Wills.** The State of New York does not specifically have a Living Will or Advance Medical Directive statute. However, New York does have a statute allowing for the designation of a health care "proxy" who may make decisions on behalf of the maker and, in this document, the maker is allowed to state his or her wishes for future treatment should he or she become incapacitated. Also, there is nothing in New York law that prevents an individual from executing a Living Will form as used in other states and combining that declaration with a naming of a health care proxy. Our standard form combines both a Living Will declaration with the naming a health care agent or proxy.
- D. **Who may be a witness under a New York proxy designation?** New York law contains the following restrictions on who can be a witness to a health care proxy:
- a. The witnesses shall state that the principal appeared to execute the proxy willingly and free from duress. The person appointed as agent shall not act as witness to execution of the health care proxy.
  - b. For persons who reside in a mental hygiene facility operated or licensed by the office of mental health, at least one witness shall be an individual who is not affiliated with the facility and, if the mental hygiene facility is also a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law, at least one witness shall be a qualified psychiatrist.
  - c. For persons who reside in a mental hygiene facility operated or licensed by the office of mental retardation and developmental disabilities, at least one witness shall be an individual who is not affiliated with the facility and at least one witness shall be a physician or clinical psychologist who either is employed by a school named in section 13.17 of the mental hygiene law or who has been employed for a minimum of two years to render care and service in a facility operated or licensed by the office of mental retardation and developmental disabilities, or who has been approved by the commissioner of mental retardation and developmental disabilities in accordance with regulations approved by the commissioner. Such regulations shall require that a physician or clinical psychologist possess specialized training or three years experience in treating developmental disabilities.  
New York Statutes, [Consolidated Laws, Public Health, Ch. 45, Sections 2981](#).
- E. **Who may be a health care proxy?** New York law contains the following restrictions on who can be a health care proxy:
- a. An operator, administrator or employee of a hospital may not be appointed as a health care agent by any person who, at the time of the appointment, is a patient or resident of, or has applied for admission to, such hospital.
  - b. The restriction in paragraph (a) of this subdivision shall not apply to:
    - (i) an operator, administrator or employee of a hospital who is related to the principal by blood, marriage or adoption; or
    - (ii) a physician, subject to the limitation set forth in paragraph (c) of this subdivision, except that no physician affiliated with a mental hygiene facility or a psychiatric unit of a general hospital may serve as agent for a principal residing in or being treated by such facility or unit unless the physician is related to the principal by blood, marriage or adoption.
  - c. If a physician is appointed agent, the physician shall not act as the patient's attending physician after the authority under the health care proxy commences, unless the physician declines the appointment as agent at or before such time.
  - d. No person who is not the spouse, child, parent, brother, sister or grandparent of the principal, or is the issue of, or married to, such person, shall be appointed as a health care agent if, at the time of appointment, he or she is presently appointed health care agent for ten principals.  
New York Statutes, [Consolidated Laws, Public Health, Ch. 45, Sections 2981](#).
- F. We recommend that you execute two originals of your Health Care Directive. Give the first original to the Health Care Agent you named and you retain the second original in your home in place known to family members. If you currently under medical care for a serious medical condition, we also suggest you execute a third original and give it to your primary physician.

- G. Where do I get a notary? Your local bank is the best place to find a notary. If you cannot find a notary at your bank, please consult your local Yellow Pages which has them listed under "notaries public".
- H. Notice: This form is not intended for use in the State of Wisconsin.
- I. What if I decide to make changes to my document? We will keep your responses to the online questionnaire in our database **for 60 days after the date of purchase**. During this time, you may go to the User Administration section of our site to call up your form questionnaire and make changes--the URL is <https://www.medlawplus.com/user/>. You shall need your "user name" and "password" to re-enter the system. Once in the User Administration area, click on the text link to your form questionnaire which is located on the upper-left of the page. Make the desired changes to your responses in the questionnaire and submit to create a revised document. If you have problems calling up your old data, email us at [administrator@medlawplus.com](mailto:administrator@medlawplus.com). We do our best to give a prompt response to all inquiries, usually within a few hours. NOTE: Upon registration, our system emailed to you our record of your "user name" and "password".

### **DISCLAIMER**

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