

BUFFALO AMBULATORY SURGERY CENTER
NEW YORK STATE HEALTH CARE PROXY

This form lets you appoint someone you trust to make health care decisions if you become unable to make them yourself. It is not limited to your care at BASC.

1. Appointment of Health Care Agent

I, _____, hereby appoint:

Agent name: _____

Home address: _____

Telephone number: _____

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

2. Alternate Health Care Agent (optional)

If my agent is unable, unwilling, or unavailable to act, I appoint:

Alternate agent name: _____

Home address: _____

Telephone number: _____

3. Expiration (optional)

Unless I revoke it or state an expiration date or condition, this proxy will remain in effect indefinitely.

This proxy shall expire (date or condition):

4. Special Instructions or Limitations (optional)

You may state wishes, instructions, or limits on your agent's authority. Discuss artificial nutrition and hydration with your agent; your agent must know your wishes to make decisions about them.

I direct my agent to make decisions in accordance with my wishes and instructions as stated here or otherwise known to my agent, and to follow any limitations on their authority.

5. Your Identification and Signature

Your name (print): _____

Your address: _____

Signature: _____ Date: _____

HEALTH CARE PROXY | SIGNATURES & WITNESSES

6. Organ, Eye and/or Tissue Donation (optional)

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

☐ Any needed organs, eyes and/or tissues

☐ The following organs, eyes and/or tissues: _____

☐ Limitations: _____

Leaving this section blank does not mean that you oppose donation or prevent someone otherwise authorized by law from consenting on your behalf.

Signature: _____ Date: _____

7. Statement by Witnesses

Witnesses must be at least 18 years old. Neither the appointed agent nor the alternate agent may serve as a witness.

I declare that the person who signed this document is personally known to me or has established their identity to my satisfaction, appears to be of sound mind, and signed (or directed another person to sign) willingly and free from duress, in my presence. I am not appointed as an agent by this document.

Witness 1

Printed name: _____

Address: _____

Signature: _____ Date: _____

Witness 2

Printed name: _____

Address: _____

Signature: _____ Date: _____

Important information

- Sign and date this form in the presence of two adult witnesses, who must also sign. Notarization is not required.
- Your agent makes decisions only after you are determined to lack decision-making capacity. You may revoke this proxy as permitted by New York law.
- Give copies to your agent, alternate agent, health care providers, and BASC for your medical record.
- This form does not itself constitute a do-not-resuscitate (DNR) order.

BASC patient record: Patient name _____ DOB _____