

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I understand that, as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and will turn to someone who knows my values and health care wishes. By signing this appointment of health care representative, I appoint a health care representative with legal authority to make health care decisions on my behalf in such case or at such time.

I appoint _____ whose address is _____ to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, **my health care representative is authorized make any and all health care decisions for me, including (1) the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law such as psychosurgery or shock therapy, as defined in Conn. Gen. Stat. § 17a-540, and (2) make the decision to provide, withhold or withdraw life support systems, unless I have specified otherwise in this document. This appointment shall take effect: (Check one) when I am unable to make my own health care decisions immediately.**

I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes. I direct my health care representative to make decisions on my behalf in accordance with the following limitations and/or instructions: _____

If _____ is unwilling or unable to serve as my health care representative, I appoint _____ whose address is _____ to be my alternative health care representative.

If a conservator of my person should need to be appointed, I designate: (Check one)

My health care representative and alternate health care representative (if any) be appointed my conservator.

_____ [Conservator name] whose address is _____ be appointed my conservator. If _____ [Conservator name] is unwilling or unable to serve as my conservator, I designate _____ [Successor conservator Name] whose address is _____ be successor conservator.



(Check if applicable)

No bond shall be required of in any jurisdiction.

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. I give: (Check one) any needed organs, tissues, or parts only the following organs or parts: -

_____ to be donated for: (Check one)

These limited purposes: _____

Any purpose authorized by law. Any needed organs or parts to be donated for any of the purposes stated in subsection (a) of Conn. Gen. Stat. §19a-289j, including (i) a hospital; accredited medical school, dental school, college or university; organ procurement organization; or other appropriate person, for research or education; (ii) a named individual designated by me if the individual is the recipient of the part; and (iii) an eye bank or tissue bank.

I further instruct that, as required by law, my attending physician disclose to my health care representative protected health information regarding my ability to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment at the representative's request made at anytime after I sign this form.

SIGNATURE

This appointment is made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

Principal's Signature

Date

Principal's Name

Principal's Address

City

State

Zip Code



WITNESSES' STATEMENT

This document was signed in our presence by _____, the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

First Witness

Witness 1 Signature _____ Date _____

Witness 1 Name _____

Witness 1 Address _____

City _____ State _____ Zip Code _____

Second Witness

Witness 2 Signature _____ Date _____

Witness 2 Name _____

Witness 2 Address _____

City _____ State _____ Zip Code _____



NOTARY PUBLIC ACKNOWLEDGEMENT

STATE OF CONNECTICUT)
) ss: _____
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author’s instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author’s presence, at the author’s request, and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author’s request this ____ day of _____, 20 ____

Witness 1 Signature

Witness 2 Signature

Subscribed and sworn to before me by _____ and _____,
the signing witnesses to the foregoing affidavit this ____ day of _____, 20 ____.

Commissioner of the Superior Court
Notary Public

(Printed Name)

My Commission expires: _____

