MEDICAL RECORD NUMBER:

NAME:

BIRTH DATE:

DELIVERY NETWORK:

CMG COMMUNITY MEDICAL GROUP

Yale NewHaven Health Northeast Medical Group

Yale Medicine

Appointment of Health Care Representative/Agent

I _____ understand that, as a competent adult, I have the right to make decisions about my health care. However, there may come a time when I am unable to make my own health care decisions due to illness or incapacity. In these circumstances, those caring for me will need direction from someone who knows my values and health care wishes. By signing this appointment of health care representative/agent, I give the person named below legal authority to make health care decisions on my behalf in such case or at such time.

I appoint – Name _____

Address _____

Phone number _____

Cell phone number _____

to be my health care representative/agent. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment, **my health care representative/agent is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, (2) make the decision to provide, withhold or withdraw life support systems and (3) to receive any health care information about me that might be necessary to make these decisions, including information related to my mental health or HIV status.**

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

If this person is unwilling or unable to serve as my health care representative/agent, I appoint:

Name _____

Address _____

Phone number _____

Cell phone number _____

to be my alternative health care representative/agent.

This request is made, after careful reflection, while I am of sound mind and will remain in effect unless and until it is revoked in accordance with state law.

Date | Patient's Printed Name | Patient's Signature

WITNESSES' STATEMENTS

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

Date | Witness Printed Name | Witness Signature

Address | City | State | Zip Code

Second Witness

Date | Witness Printed Name | Witness Signature

Address | City | State | Zip Code

INSTRUCTIONS FOR SCANNING INTO EPIC

1. Scan into Media Manager
2. For document type, select "Healthcare Representative/POA"