-NEW YORK-

HEALTH CARE PROXY

INSTRUCTIONS

PRINT NAME

(1) I, _____ hereby appoint
(name)

PRINT NAME, HOME ADDRESS, TELEPHONE NUMBER OF AGENT

_____
(name, home address, and telephone number of agent)

_____

as my health care agent to make any and all health care decisions for me (except to the extent that I state, otherwise). My agent does know my wishes regarding artificial nutrition and hydration.

The Health Care Proxy shall take effect in the event I become unable to make my own health care decisions.

ADD PERSONAL INSTRUCTIONS (IF ANY)

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as started below, or as he or she otherwise knows.

PRINT NAME AND TELEPHONE NUMBER OF ALTERNATE AGENT

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling, or unavailable to act as my health care agent.

_____
(name, home address, and telephone number of agent)

_____

ORGAN DONATION (OPTIONAL)

(4) Donation of Organs at Death:

[ ] I do not wish to donate my organs, tissues or parts.

[ ] I wish to be an organ donor and upon my death I wish to donate:

continued →

ORGAN DONATION (OPTIONAL) CONTINUED

[ ] **(a)** Any needed organs, tissues, or parts; OR

[ ] **(b)** The following organs, tissues, or parts

_____

_____

[ ] **(c)** My gift is for the following purposes:

(Put a line through any of the following you do not want.)

(i) Transplant

(ii) Therapy

(iii) Research

(iv) Education

ENTER A DURATION OR A CONDITION (IF ANY)

(5) Unless I revoke it, this proxy shall remain in effect indefinitely or until the date or condition I have stated below. This proxy shall expire (specific date or conditions, if desired):

_____

_____

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

(6) Signature **X**_____ Date: _____

Address: _____

WITNESS PROCEDURE

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document appeared to execute the proxy willingly and free from duress. He or she signed (or asked another to sign) this document in my presence. I am not the person appointed as proxy by this document.

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1 _____

Address _____

Witness 2 _____

Address _____

Patient Authorization For Use and Disclosure of Protected
Health Information To The Practice From Another Office

MEMO TO:

_____
Name of Doctor, Hospital, Clinic or other Health Care Provider

_____
Address City State Zip

MEMO FROM:

_____
Name of Patient Date of Birth

Dear Provider Office Or Medical Facility:

My doctor has provided this HIPAA compliant request authorization form in order to assist me in requesting you to forward copies of my medical records.
By signing this authorization, I request and authorize you to use and/or disclose certain protected health information about me to: O'Connor Medical Group
3075 Southwestern Blvd Suite 100
Orchard Park, NY 14127
Fax: 716-712-0615

This authorization permits you to use and/or disclose the following individually identifiable health information about me including all progress notes, diagnostics and immunization records.

Also send the sensitive information checked below:

__Chemical Dependency Records
__Mental Health Records
__ HIV related information

The information will be used or disclosed for future medical care.
This authorization will expire in 90 days.

When my information is used or disclosed pursuant to this authorization it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that your office acted in reliance upon this authorization. My written revocation must be submitted to your Privacy Officer at the address listed above.
Signed By:_____ Date_____
Relationship to Patient:_____