Health Care Proxy (醫療護理委託書)

(1) I (本人)**,**_____

hereby appoint (在此指定)_____

(*name, home address and telephone number*) (姓名 家庭地址和電話號碼)

_____

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

作為我的醫療護理代理人 為我做出任何以及所有的醫療護理決定 除非我另外聲明。只有在我法做出我的醫療護理決定時候 這份委託方能生效。

(2) Optional: Alternate Agent (備選 預備代理人)

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint

如果我指定的人士不能　不願意或者難以擔任我的醫療護理代理人 我在此指定

_____

(name, home address and telephone number) (姓名 家庭地址和電話號碼)

_____

_____

As my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

作為我的醫療護理代理人 為我做出任何以及所有醫療護理決定。除非我另外聲明。

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire (*specify date or conditions)*:

除非我取消或者說明失效日期或失效條件 否則 這份委託書將無期限有效。(任選 如果您希望此份委託失效 請在此規定日期或者條件。) 此委託將會在以下(確定日期或條件下) 失效

_____

_____

(4) I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. (*If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.*) I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (*attach additional pages as necessary*):

任選 我指示我的醫療護理代理人根據我的願望和限制做出醫療護理決定 與他或者她所瞭解的情況或者下述情況一樣。(如果您想限制您的代理人為您做出醫療護理決定的權限 或者給出特別的示您可以在此表明您的願望或者限制。)我指示我的醫療護理代理人根據下列限制和/或指示做出療護理決定 (必要的話附上另外的說明)

_____

_____

Please note that in order for your agent to make health care decisions for you about artificial nutrition and hydration (*nourishment and water provided by feeding tube and intravenous line*), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in the above section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.
為了讓您的代理人就人工營養和流質食物做出醫療護理決定(通過進食管和靜脈提供營養和水) 的代理人必須適度瞭解您的願望。您可以告訴您的代理人您的願望 或者在此處說明。如果您希望把您的願望 包括您在人工營養和流質食物方面的願望 寫在表格上 請參考以上有關您可以使用的語言的例子。

(5) I also grant authority and power to my agent(s) to serve as my personal representative for purposes of the Health Insurance Portability and Accountability Act (HIPAA). My agent is authorized to execute any and all releases and other documents necessary in order to obtain disclosure of my patient records and other medical information subject to and protected by HIPAA.
我同時亦授權給我的代理人,成為健康保險私隱權法案(HIPAA)的個人代表, 我的代理人有權執行任何或發佈我的資料, 以便獲得及受HIPAA保障的病歷。

(6) Your Identification *(please print)* (您的身份(請用大寫字母寫出))

Name (姓名)_____

Signature (簽名) _____ Date(日期)_____

Address (地址)_____

(7) Witnesses: Two witnesses must be 18 years of age or older and cannot be the health care agent or alternate.
證人聲明 (證人必須18歲或以上 並且不能成為醫療護理代理人或者預備代理人。)
I declare that the person who signed this document appeared to execute the Health Care Proxy willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.
我聲明 我本人認識在此份文件上簽字的人。此位人士心志健全 並且是在自願的情況下填寫這份表格的。他或者她在我面前在這份文件上簽字(或者請另一個人代他簽名) 。

Witness 1 (第一位證人)***:***

Name *(please print)*: _____
姓名 (用大字母寫出)
Signature: _____
簽名
Address: _____
地址
Date: _____
日期

Witness 2 (第二位證人)***:***

Name *(please print)*: _____
姓名 (用大字母寫出)
Signature: _____
簽名
Address: _____
地址
Date: _____
日期

(8) Optional: Organ and/or Tissue Donation (任選 器官 和 / 或 組織捐獻)

I hereby make an anatomical gift, to be effective upon my death, of:
我在此同意捐獻一份解剖學贈品 在我死亡時生效

(check any that apply)
(請選出所有合適的項目)

☐ Any needed organs and/or tissues (任何需要的器官和 / 或組織)

☐ The following organs and/or tissues (下列器官和 / 或組織)_____
_____

☐ Limitations (限制條件)_____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.
如果你不在這份表格上表明您在器官和/或組織捐獻方面的願望或指示 並不表示您不希望捐獻也並不表示不可以由法律認可的人士代表您同意捐獻。

Your Signature (您的簽名)_____ Date (日期)_____

Your Address (您的地址)_____

U.S. Living Will Registry®
Registration Agreement

Source Code
37125901

Registrant's Identifying Information (Please type or print clearly)

Name: First_____ Middle_____Last _____ Suffix _____

Social Security Number:_____ _____ _____Date of Birth: Month _____Day_____Year_____(4 digits, please)

Address - Primary Residence: Street Address _____ Apt #_____

City _____ State _____ Zip Code _____

Secondary Residence (if any): Street Address_____Apt #_____

City _____ State_____ Zip Code _____

Phone- Home: ( ) _____Work: ( )_____Secondary Res: ( )_____

Emergency Contact #1: Name:_____ Relationship:_____

Address:_____

Telephone Number: Home: ( )_____ Work/Other: ( )_____

Emergency Contact #2: Name:_____Relationship:_____

Telephone Number: Home: ( )_____Work/Other: ( )_____

I,_____ ("Registrant" or "I"), request that the *U.S. Living Will Registry*®, with offices at 523 Westfield Ave., PO Box 2789 Westfield, New Jersey 07091-2789 ("Registry"), electronically store a copy of my attached advance directive (collectively, including but not limited to my: living will, health care proxy, or similar document[s], including organ donor information, provided to the Registry), and provide a copy of the stored advance directive image to any health care provider who requests it in conjunction with my care. A "health care provider" is any hospital, doctor, skilled nursing facility, nursing facility, home health care agency/provider, ambulatory surgery facility, hospice, or any authorized employee, contractor or agent of any of the foregoing, or other person believed charged with giving effect to my advance directive or assisting in same. I voluntarily execute this registration on the date set forth below, without coercion, duress or undue influence from any party, and I warrant and represent that I have the legal capacity to offer my consent to such registration. My registration is not effective until I receive written confirmation from the Registry, at the above address. I can only register through a Registry member Health Care Provider or a Registry Community Partner. The Registry's member Health Care Providers and Community Partners are not owned or operated by the Registry, and they cannot change any terms of this Registration Agreement; any oral changes are not effective. Only the Registry can change the terms of the Registration Agreement, and only in writing (except in emergencies, in the Registry's sole discretion). I have provided my Social Security number to facilitate the identification, retrieval and provision of my stored advance directive images to health care providers, and for the Registry's recordkeeping purposes only.

I. Registration and Certification: I submit the information contained herein to confirm my identity, in the event that a health care provider requests a copy of my advance directive. I certify that this information is correct and that the attached advance directive is my currently effective advance directive, which was properly executed in accordance with the laws of the state where it was executed. If the attached advance directive is a copy, I certify that it is a true and correct copy of the original document. I agree to immediately notify the Registry, in writing, at the Registry's address listed above, in the event of my revocation of the attached advance directive or of this registration, or if the attached advance directive or the identifying information herein are changed in any way. I agree immediately to provide the Registry with a copy of the new/changed documents. I will indemnify and hold the Registry harmless for any damages resulting from the Registry's reliance on these certifications, or on any inaccurate information I supplied. If I don't notify the Registry in writing and in a timely manner of any changes, or of the revocation of my advance directive or this registration, or if I don't provide a true copy of the changed documents to the Registry, the Registry will not be liable for any damages resulting from the production of the documents on file to any health care provider. If my information is accessed over the Internet utilizing my unique

registration number, my social security number ("SSN") will not be revealed, and it will not be visible or disclosed on the Registry's web page. If the card containing my unique registration number is lost or otherwise unavailable, health care providers will be able to access my documents using my SSN. Since most health care providers have access to their patients' SSN, providing your SSN to the Registry ensures the widest availability of your advance directive images to health care providers in time of need, even when your card is not available. The Registry will take appropriate steps to safeguard the privacy and confidentiality of each Registrant's SSN, and the Registry will not use SSNs for any purposes not specifically permitted by this Registration agreement. If you do not provide your SSN, your documents will be identified only by the unique registration number assigned by the Registry, which will significantly limit the accessibility of your documents.

II. Authorization: I authorize the Registry to send a copy of my advance directive to any health care provider (as defined herein) that requests a copy of it, provided the request conforms to the Registry's policies and procedures (or as deemed advisable by the Registry in an emergency situation, or as required by law). The Registry is not otherwise authorized to share my personal information with parties other than health care providers (as defined herein). A copy of this Agreement may be used in place of the original document.

III. Limitations on Liability: I understand that I will not be charged a fee to register or to maintain my registration. Registry shall not be liable to me or any person or entity for any liability arising from the improper transmission/disclosure of my advance directive, from the transmission of inaccurate or incomplete materials, or from the loss/misplacement/destruction/unavailability of all or part of my advance directive. If I don't agree to these terms, I am free not to use the Registry's service.

IV. Term: This Agreement shall remain in effect until Registry receives reliable information that the Registrant is deceased, the Registrant requests, in writing, that the Agreement be terminated, or until registration is cancelled pursuant to the Registry's policies and procedures. When the Agreement is terminated, Registry will use best efforts to remove Registrant's advance directive from its files.

I hereby agree to the terms herein, and certify the accuracy of the information provided. I agree to safeguard my Registration ID card from unauthorized access. I understand that anyone who gains access to my card can use it to gain access to my documents and personal information (but not to my SSN), and I will not hold the Registry liable for such unauthorized access.

X_____ DATED: _____/_____/_____
Signature of Registrant

WITNESS STATEMENT

I declare that the Registrant who signed this document is personally known to me, that he/she signed or acknowledged this document in my presence, and that he/she appears to be of sound mind, and under no duress or undue influence.

Signature: _____ Print Name: _____
(Witness #1) DATED: _____/_____/_____

Signature: _____ Print Name: _____
(Witness #2) DATED: _____/_____/_____