Health Care Proxy

(1) I, _____, hereby appoint _____, residing at _____, whose telephone number is _____, 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 when and if I become unable to make my own health care decisions.

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

This health care proxy contains no limitations. I have discussed my wishes with my Agent and Substitute Agent and each knows my wishes concerning artificial nutrition and hydration.

(3) Optional: I hereby make an anatomical gift, to be effective upon my death of: (check all that apply)

- ☐ Any needed organs and/or tissues
- ☐ The following organs and/or tissues: _____
- ☐ Limitations: _____

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.

(4) 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: _____, residing at _____, whose telephone number is _____.

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

(6) Signature: _____

Address: _____

Date: _____

Statement by Witnesses (must be 18 or older and cannot be the health care agent or alternate): I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 _____

Address _____

Witness 2 _____

Address _____

DAVIDOW, DAVIDOW, SIEGEL & STERN, LLP

Islandia Office
1050 Old Nichols Road
Suite 100
Islandia, NY 11749

Mattituck Office
P.O. Box 344
13235 Main Road
Mattituck, NY 11952

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

HIPAA Release Form

I, _____, hereby authorize the release of my individually identifiable protected health information to my "personalrepresentative" pursuant to 45 C.F.R. Section 164.502 (g)(2).

I intend that my "personal representative" be treated as I would, with respect to my rights regarding the use and disclosure of my individually identifiable protected health information and/or any other medical records.

I authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other health care provider, insurance company, Medical Information Bureau, Inc. (or other healthcare clearing-house), or any other health care provider that has provided treatment or services to me or that has paid for or is seekingpayment for such services; to give, disclose and release to my "personal representative," without restriction, all of my individually identifiable health care information and medical records regarding past, present or future medical or mental health conditions.

This authorization shall supersede any prior agreement I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. This authorization has no expiration date and shall not require any re-authorization by me at any particular time interval and may be revoked by me in writing and delivered to my health care provider.

For purposes of this release, the term "personal representative" shall include but shall not be limited to the agent under a "Health Care Proxy."

_____
Signature

_____
Date

Witnesses:

_____

_____

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