Medical Health Care Proxy

The primary physician of _____ has advised the following "interested parties" who
(patient name)
may include a spouse, parent, adult children, brother or sister, grandchildren or close friend(s),
that _____ lacks decisional capacity in matters of personal health care
(patient name)
and so is not able to give informed consent to or refusal of medical treatment, use of cardio-pulmonary resuscitation or the administration of artificial nourishment or hydration to prolong the act of dying.

By consensus, the undersigned agree that _____ should act as
(Designated Proxy Decision Maker)
Proxy Decision Maker for _____ with respect to any and all decisions
(patient name)
without limitations with respect to termination or withholding of life support in accordance with the authority set forth under Colorado law, Section 15-18.6 of the Colorado Revised Statues.

_____

Signature *Date* *Relationship*

_____

Signature *Date* *Relationship*

_____

Signature *Date* *Relationship*

_____

Signature *Date* *Relationship*

The foregoing instrument was signed and declared by _____as his/her voluntary act.
(Designated Proxy Decision Maker)

on this _____ day of _____, 20_____.

State of Colorado
County of _____

Witness my hand and seal Notary Public _____

My Commission expires: Address _____

Each medical institution has an individually designed Medical Health Care Proxy Form.
An individual may have to sign a separate form for each health care institution, such as a hospital, nursing home, or hospice if the patient receives care in more than one institution.