State Senator
Jeff Klein

Your Health Care Rights & Responsibilities

District Office • 3713 East Tremont Avenue, Bronx, New York 10465 • (718) 822-2049
• Mount Vernon Armory, 144 North 5th Avenue • (800) 718-2039
• Pelham Town Hall, 195 Sparks Avenue • (800) 718-2039
Albany Office • 415 Legislative Office Building, Albany, New York 12247 • (518) 455-3595

Dear Friend,

Terri Schiavo's tragic death has many of us thinking about the confusion often caused by end-of-life decisions. We all have ideas about how we would like to be cared for in the unfortunate event an illness or accident ever leaves us temporarily or permanently incapable of making our own decisions.

There are two ways to help ensure that your health care wishes will be respected: a health care proxy and a living will. Both documents make your wishes known as to what life support treatments you accept or refuse in the event you become incapacitated. Writing a living will and appointing a health care proxy can ease the anguish of your relatives and loved ones in the event of a tragedy.

The following pages of this brochure explain the health care proxy and present you with an example. I urge you to fill out this document today. I hope you find this information helpful. You can also find more information on the living will in this brochure.

As always, if you have any questions or need further assistance, do not hesitate to contact me.

Sincerely,

Jeff Klein
Senator, 34th Senatorial District

Living Wills

If you are interested in planning ahead for your health care, but don't have anyone you wish to designate as your health care agent, you might want to prepare a "living will" as an alternative. A living will also allows you to make your wishes about future medical treatment known. For information about living wills, and sample forms, you may contact the New York State Bar Association at 518-463-3200 or visit www.nysba.org.

Your Health Care Right

Did you know that, as a patient in a New York State hospital, you have certain protections guaranteed by State and Federal laws? These regulations exist to help ensure the quality and safety of your hospital care. Please review these rights before you go into the hospital for treatment.

Patient's Bill of Rights

While hospitalized in New York State, you have the right to:

(1) Understand and use these rights. If for any reason you do not understand or you need further assistance, the hospital MUST provide assistance, including an interpreter, if necessary.

(2) Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation or source of payment.

(3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

(4) Receive emergency care if you need it.

(5) Be informed of the name and position of the doctor who will be in charge of your care in the hospital.

(6) Know the names, positions and functions of any hospital staff involved in your care, as well as your right to refuse their treatment, examination and observation.

(7) Be placed in a non-smoking room.

(8) Receive complete information about your diagnosis, treatment and prognosis.

(9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

(10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give consent for you if you are too ill to do so. If you would like additional information, please ask your social worker or patient representative for a copy of the pamphlet *"Do Not Resuscitate Orders – A Guide for Patients and Families."*

(11) Refuse treatment and be told what effect such refusal may have on your health.

(12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.

(13) Privacy while in the hospital and confidentiality of all information and records regarding your care.

(14) Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.

(15) Review your medical records without charge. Obtain a copy of your medical records for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.

(16) Receive an itemized bill and explanation of all charges.

(17) Complain without fear of reprisals about the care and services you are receiving and have the hospital respond to you if requested. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department at (212) 268-6477.

(18) Authorize family members and other adults who will be permitted to visit depending upon your ability to receive visitors.

(19) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card that is available from the hospital.

Please do not hesitate to contact my District Office if you have any questions on the Patient's Bill of Rights.

For further assistance, please call the Hospital Patients' Rights Hotline at (800) 333-4374.

ts and Responsibilities

About the Health Care Proxy

This is an important legal form. Before signing this form, you should understand the following facts:

1) This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent that you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2) Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or withhold life-sustaining treatment.
3) Unless you have given your agent oral or written instructions about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse those measures for you.

Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

- If I become terminally ill, I do/don't want to receive the following treatments...
- If I am in a coma or unconscious, with no hope of recovery, then I do/don't want...
- If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want...

Examples of medical treatments that you may wish to give your agent special instructions about are listed below. This is not a complete list of the treatments, just a guide.

- artificial respiration
- artificial nutrition and hydration *(nourishment and water provided by feeding tube)*
- cardiopulmonary resuscitation *(CPR)*
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker, before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. You do not need a lawyer to fill out this form.

You can choose any adult (over 18), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she may have to choose between acting as your agent or as your attending doctor; a physician cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home, or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask staff at the facility to explain those restrictions.

You should tell the person you choose that he or she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object. You can cancel the control given to your agent by telling him or her or your health care provider orally or in writing.

Filling out the Proxy Form

(on back page)

Item (1) Write your name and the name, home address and telephone number of the person you are selecting as your agent.

Item (2) If you have special instructions for your agent, you should write them here. Also, if you wish to limit your agent's authority in any way, you should say so here. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

Item (3) You may write the name, home address and telephone number of an alternate agent.

Item (4) This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire.

Item (5) You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Two witnesses at least 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.

Health Care Proxy

(1) I, _____,

hereby appoint _____
(name, address and telephone number)

_____

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 instructions: I direct my proxy to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows (Attach additional pages if necessary).

_____

_____

_____

(Unless you have given your agent oral or written instructions about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration. See instructions for samples of language you could use to make your wishes clear about these treatments.)

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

_____
(name, address and telephone number)

_____

(4) 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):

_____

(5) Signature _____ Date _____

Address _____

_____

Statement by Witnesses (must be 18 or older)

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 _____