



**MASSACHUSETTS HEALTH CARE PROXY FORM**

W  
H C A H C A H C P  
/ H C P  
H C P  
(18)

W : P N :

A :

W : P N :

A :

**STATEMENT OF HEALTH CARE AGENT (OPTIONAL)**

Health Care Agent: I, \_\_\_\_\_ ( )  
Health Care Agent \_\_\_\_\_ H C P I, \_\_\_\_\_