

DESIGNATION OF HEALTH CARE SURROGATE

Name: _____, of _____(city), _____ (state)

In the event that I have been determined to be incapacitated and/or incompetent to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: _____
Address: _____
Phone: _____

If surrogate listed above is unavailable, unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: _____
Address: _____
Phone: _____

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional instructions (optional): *I have executed a Living Will. Please refer to that document as needed.*

I have executed a Living Will requesting life prolonging procedures to be withheld or withdrawn pursuant to Florida Statutes 765.01-765.15. My health care surrogate designated herein is hereby authorized to consent to the withholding or withdrawing of life prolonging procedures for me pursuant to Florida Statutes 765.01-765.15.

Health Insurance Portability and Accountability Act (HIPAA): For the purposes of accessing, reviewing and releasing my health care information and any other protected information pursuant to HIPAA, my health care surrogate or my alternative health care surrogate shall be considered my personal representative under HIPAA and have the full and complete authority to access, review and/or release any and all of my health care information and any other protected information.

Other parties: No private or government entity shall have any control, influence or direction over the decision of my designated surrogate.

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: _____

Name: _____

Witness: _____

Signed: _____

Witness: _____

Date: _____