DESIGNATION OF HEALTH CARE SURROGATE

I, **CLIENT**, designate my \_\_\_\_\_\_\_\_\_\_\_\_\_, **AAAA**, whose current address is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and whose current telephone number is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to serve as my health care surrogate under Section 765.202 of the Florida Statutes, to receive all of my health information and to make all health care decisions for me, to be effective immediately. In addition, I designate my health care surrogate as my personal representative under 45 CFR §164.502(g), a portion of the regulations implementing the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), for all health care-related decisions. If **AAAA** is unwilling or unable to perform his duties, then I designate my \_\_\_\_\_\_\_\_\_\_\_, **BBBB**, whose current address is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and whose current telephone number is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to serve as my health care surrogate. If **BBBB** is also unwilling or unable to perform his duties, then I designate my \_\_\_\_\_\_\_\_\_\_\_, **CCCC**, whose current address is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and whose current telephone number is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to serve as my health care surrogate. If **CCCC** is also unwilling or unable to perform his duties, then I designate my \_\_\_\_\_\_\_\_\_\_\_, **DDDD**, whose current address is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and whose current telephone number is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to serve as my health care surrogate.

This health care surrogate designation is not affected by my subsequent incapacity except as provided in Chapter 765 of the Florida Statutes, and will remain in effect until I revoke it. I affirm that this designation is not being made as a condition of treatment or admission to a health care facility. Other provisions intended to expand and clarify this designation are included on the attached pages.

This designation of health care surrogate is executed by me on Month \_\_\_, 2020.

Signed in the presence of:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **CLIENT**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Note: The person designated as the health care surrogate cannot act as a witness to the execution of this designation. At least one witness must be a person who is neither the spouse nor a blood relative of the person making the designation.]

STATE OF FLORIDA
COUNTY OF ALACHUA

The foregoing instrument was acknowledged before me on Month \_\_\_, 2020, by **CLIENT**.

Physical Presence \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Remote Notarization \_\_\_\_\_\_\_\_ Notary Public--State of Florida

Personally Known \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Notary Name:
Produced Identification \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ My Commission Number is:
Type of Identification \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ My Commission Expires:

Declarant's Statements

While I have decision making capacity, my wishes are controlling and my physicians and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.

To the extent I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions made on my behalf and matters concerning me.

I understand that I may revoke or amend this designation while I possess capacity by:

* signing a written and dated instrument expressing my intent to amend or revoke this designation;
* physically destroying this designation myself or directing another person to do so in my presence;
* verbally expressing my intention to amend or revoke this designation; or
* signing a new designation that is materially different from this designation.

Any verbal or written instructions or health care decisions I make while I possess capacity will supersede any instructions or health care decisions made by my surrogate that materially conflict with mine.

I will furnish an exact copy of this designation to my health care surrogate and my alternate surrogate if I have named one.

Responsibilities of the Health Care Surrogate

By way of example and not in limitation, my health care surrogate may:

* act for me and to make all health care decisions for me in matters during my incapacity, as she deems to be in my best interest, and to execute on my behalf any documents necessary to implement such health care decisions;
* consult expeditiously with any health care providers to provide informed consent in my best interest, and to make health care decisions which she believes I would have made under the circumstances if I were capable of making such decisions;
* provide written consent using an appropriate form provided by any health care provider, including a physician's order not to resuscitate;
* request, receive and review any information concerning my mental and physical health, including but not limited to medical and hospital records and other protected health information as defined by HIPAA;
* apply for public and veterans' benefits, such as Medicare and Medicaid, for me and to have access to information regarding my income and assets and banking and financial records to the extent required to make application;
* authorize the release, use and disclosure of records including the protected health information described above to appropriate persons as necessary to ensure the continuity of my health care;
* authorize my admission to or transfer from a licensed health care facility;
* carry out the terms of any living will or declaration made by me; and
* decide to make an anatomical gift pursuant to Chapter 765 of the Florida Statutes.

Definitions

For purposes of this declaration, the following statutory terms are defined as:

"Health care" means care, services, or supplies related to the health of an individual and includes, but is not limited to, preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the individual's physical or mental condition or functional status or that affect the structure or function of the individual's body.

"Health care decision" means:

(a) Informed consent, refusal of consent, or withdrawal of consent to any and all health care, including life-prolonging procedures and mental health treatment, unless otherwise stated in the advance directives.

(b) The decision to apply for private, public, government, or veterans' benefits to defray the cost of health care.

(c) The right of access to health information of the principal reasonably necessary for a health care surrogate or proxy to make decisions involving health care and to apply for benefits.

(d) The decision to make an anatomical gift pursuant to Chapter 765 of the Florida Statutes.

"Health information" means any information, whether oral or recorded in any form or medium, as defined in 45 C.F.R. s. 160.103 and the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. s. 1320d, as amended, that:

(a) Is created or received by a health care provider, health care facility, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

(b) Relates to the past, present, or future physical or mental health or condition of the principal; the provision of health care to the principal; or the past, present, or future payment for the provision of health care to the principal.

"Incapacity" or "incompetent" means the patient is physically or mentally unable to communicate a willful and knowing health care decision. They represent the opposite of "capacity." For the purposes of making an anatomical gift, the terms also includes a patient who is deceased.

"Informed consent" means consent voluntarily given by a person after a sufficient explanation and disclosure of the subject matter involved to enable that person to have a general understanding of the treatment or procedure and the medically acceptable alternatives, including the substantial risks and hazards inherent in the proposed treatment or procedures, and to make a knowing health care decision without coercion or undue influence.

Other defined terms can be found in Section 765.101 of the Florida Statutes.

LIVING WILL DECLARATION

I, **CLIENT**, willfully and voluntarily make this declaration on Month \_\_\_, 2020. I recognize that death is natural and is but a phase in the cycle of life. I do not fear death as much as I fear the indignity and futility of deterioration, dependence, and hopeless pain. If there is no reasonable medical expectation of my recovery from a physical or mental disability, I do not wish to be kept alive by artificial means or heroic measures.

Therefore, if my attending or treating physician and another consulting physician determine that there is no reasonable medical probability of my recovery from any of the following conditions, I direct that life-prolonging procedures be withheld or withdrawn when the application of those procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain, even if that hastens my death:

* I have a terminal condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which can be expected to cause my death if not treated.
* I am in an irreversible end-stage condition that is caused by injury, disease, or illness that has resulted in severe and permanent deterioration, indicated by my incapacity and complete physical dependency, for which treatment would be medically ineffective to a reasonable degree of medical certainty.
* I am in a persistent vegetative state characterized by permanent and irreversible unconsciousness in which there is an absence of voluntary action or cognitive behavior of any kind by me, with an inability to communicate or interact purposefully with others in the environment around me.

In any of the situations described above, I direct that the following medical interventions that I have initialed be considered life-prolonging procedures, and therefore not applied or continued.

\_\_\_\_\_\_\_\_\_ Placement or continuance on a ventilator or other mechanical device, including internally implanted devices, or dialysis treatment

\_\_\_\_\_\_\_\_\_ Surgical procedures and blood transfusion, except as needed to prevent or alleviate suffering

\_\_\_\_\_\_\_\_\_ Placement in an intensive care unit except as an absolute necessity to relieve suffering

\_\_\_\_\_\_\_\_\_ Chemotherapy or radiation therapy, unless there is a substantial medical probability my condition will materially improve

\_\_\_\_\_\_\_\_\_ Resuscitation efforts in the event of arrest of my heart or breathing

\_\_\_\_\_\_\_\_\_ Active treatment of a new reversible condition such as newly-discovered cancer, heart attack, or pneumonia

\_\_\_\_\_\_\_\_\_ Artificial nutrition and hydration (providing food through tubes)

\_\_\_\_\_\_\_\_\_ Artificial hydration (providing water through tubes)

I request as much as possible treatment at home or in a comfortable bed in home-like, comfortable surroundings.

If I have been determined to be unable to provide express informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I designate my \_\_\_\_\_\_\_, **AAAA**, as my surrogate to carry out the provisions of this declaration. If **AAAA** is unable to serve as my surrogate for any reason, I designate my \_\_\_\_\_\_\_\_, **BBBB**, as my surrogate. If **BBBB** is also unable to serve as my surrogate for any reason, I designate my \_\_\_\_\_\_\_, **CCCC**, as my surrogate. If **CCCC** is also unable to serve as my surrogate for any reason, I designate my \_\_\_\_\_\_\_\_\_, **DDDD**, as my surrogate.

I hereby indemnify and hold harmless my physician and any other health care providers who render care or withhold care from me in good faith if they reasonably believe such action is consistent with my wishes as expressed in this document. I further request that my family and anyone acting on my behalf follow my wishes and directives and take whatever steps are necessary, including legal action, to insure that my wishes and directives are carried out. I direct my Attorney-in-Fact or any Trustee holding funds on my behalf to make such funds available to my surrogate or anyone acting on my behalf to insure that my wishes as expressed here are carried out.

I authorize my Living Will to be registered by my surrogate, attorney, or Attorney-in-Fact in any national or regional registry for Living Wills and I authorize my Living Will to be released to any hospital, physician, or other health care provider that is rendering care or is reasonably expected to render care to me.

I intend that this declaration be honored by my family and my physicians as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. I understand that my wishes may place a heavy burden upon others, and so I make this declaration to assume sole responsibility for my decision and to mitigate any feelings of guilt that my wishes may cause.

I hereby revoke all living will declarations executed by me prior to this date. I am emotionally and mentally competent to make this declaration, and I understand its importance.

 **CLIENT**

This declaration is witnessed by us in the presence of the declarant.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness Witness

 1617 NW 16th Avenue 1617 NW 16th Avenue

 Gainesville, FL 32605 Gainesville, FL 32605

 (352) 226-8005 (352) 226-8005

STATE OF FLORIDA
COUNTY OF ALACHUA

The foregoing instrument was acknowledged before me on Month \_\_\_, 2020, by **CLIENT**.

Physical Presence \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Remote Notarization \_\_\_\_\_\_\_\_ Notary Public--State of Florida

Personally Known \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Notary Name:
Produced Identification \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ My Commission Number is:
Type of Identification \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ My Commission Expires: