Designation of Health Care Surrogate

I, _____, designate as my health care surrogate under s. 765.202, Florida Statutes:

Name _____

Street Address _____

City _____ State _____ Phone _____

If my health care surrogate is not willing, able or reasonably available to perform his or her duties, I designate as my alternate health care surrogate:

Name _____

Street Address _____

City _____ State _____ Phone _____

INSTRUCTIONS FOR HEALTH CARE

I authorize my health care surrogate to:

(Initial here) _____ Receive any of my health information, whether oral or recorded in any form or medium, that:

1. 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
2. Relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

I further authorize my health care surrogate to:

(Initial here) _____ Make all health care decisions for me, which means she or she has the authority to:

1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
2. Apply on my behalf for private, public, government, or veteran's benefits to defray the cost of health care.
3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
4. Decide to make an anatomical gift pursuant to Part V of Chapter 765, Florida Statutes.

(Initial here) _____ Specific instructions and restrictions:

_____

_____

_____

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 that he or she has made on my behalf and matters concerning me.

THE HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY SEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES.

PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND THIS DESIGNATION BY:

1. SIGNING A WRITTEN STATEMENT AND DATED INSTRUMENT WHICH EXPRESSES MY INTENT TO AMEND OR REVOKE THIS DESIGNATION;
2. PHYSICALLY DESTROYING THIS DESIGNATION THROUGH MY OWN ACTION OR BY THAT OF ANOTHER PERSON IN MY PRESENCE AND UNDER MY DIRECTION;
3. VERBALLY EXPRESSING MY INTENTION TO AMEND OR REVOKE THIS DESIGNATION;
4. SIGNING A NEW DESIGNATION THAT IS MATERIALLY DIFFERENT FROM THIS DESIGNATION.

MY HEALTH CARE SURROGATE'S AUTHORITY BECOMES EFFECTIVE WHEN MY PRIMARY PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN HEALTH CARE DECISIONS UNLESS I INITIAL EITHER OR BOTH OF THE FOLLOWING BOXES:

IF I INITIAL THIS BOX ☐, MY HEALTH CARE SURROGATE'S AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECT IMMEDIATELY.

IF I INITIAL THIS BOX ☐, MY HEALTH CARE SURROGATE'S AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME TAKES EFFECT IMMEDIATELY. PURSUANT TO SECTION 765.2014(3), FLORIDA STATUTES, ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY SHALL SUPER CEDE ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE THAT ARE IN MATERIAL CONFLICT WITH THOSE MADE BY ME.

SIGNATURES:

Sign and date the form here

Sign Your Name _____ Date _____

Print Your Name _____

Street Address _____

City _____ State _____

Signature of Witnesses:

First Witness

Signature _____ Date _____

Print Name _____

Street Address _____

City _____ State _____

Second Witness

Signature _____ Date _____

Print Name _____

Street Address _____

City _____ State _____

Designation of Health Care Surrogate for Minor

I/We, _____, the natural guardian(s) as defined in s. 744.301(1), Florida Statutes; ☐ legal custodian(s); ☐ legal guardian(s) *(Check One)* for the following minor(s):

_____ _____

_____ _____

Pursuant to s. 765.2035, Florida Statutes, designate the following person to act as my/our surrogate for health care decisions for such minor(s) in the event that I/We am/are not able or reasonably available to provide consent for medical treatment and surgical and diagnostic procedure:

Name _____

Street Address _____

City _____ State _____ Phone _____

If my/our designated health care surrogate for a minor is not willing, able, or reasonably available to perform his or her duties, I/We designate the following person as my/our alternate health care surrogate for a minor:

Name _____

Street Address _____

City _____ State _____ Phone _____

I/We authorize and request all physicians, hospitals, or other providers of medical services to follow the instructions of my/our surrogate or alternate surrogate, as the case may be, at any time and under any circumstances whatsoever, with regard to medical treatment and surgical and diagnostic procedures for a minor, provided the medical care and treatment of any minor is on the advice of a licensed physician.

I/We fully understand that this designation will permit my/our designee to make health care decisions for a minor and to provide, withhold, or withdraw consent on my/our behalf, to apply for public benefits to defray the cost of health care, and to authorize the admission or transfer of a minor to or from a health care facility.

I/We will notify and send a copy of this document o the following person(s) other than my/our surrogate, so that they may know the identity of my/our surrogate:

Name _____

Name _____

Signature _____ Date _____

Witnesses:

1. _____

2. _____