DESIGNATION OF HEALTH CARE SURROGATE

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

Name:_____

Address:_____

_____

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:_____

Address:_____

_____

Phone:_____

INSTRUCTIONS FOR HEALTH CARE

I authorize my health care surrogate to: (Initials required in blank spaces below.)

_____ 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, 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:

_____ Make all health care decisions for me, which means he or she has the authority to:

3. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.

4. Apply on my behalf for private, public, government, or veteran's benefits to defray the cost of health care.

5. 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.

_____6. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.

Specific instructions and restrictions:

While I have decision making capacity, my wishes are controlling and my physician 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 that 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.

This health care surrogate designation is not affected by my subsequent 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 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; or

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 765.204(3), Florida States, any instructions of health care decisions I make, either verbally or in writing, while I possess capacity shall supercede 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:

_____ Date _____ Sign your name

_____ Address _____ Print your name

_____

_____ City, State

Signatures of Witnesses:

First Witness

_____ Print name

_____ Address

_____ City, State

_____ Signature

_____ Date

Second Witness

_____ Print name

_____ Address

_____ City, State

_____ Signature

_____ Date

LIVING WILL

Declaration made this_____day of_____, (20____), I_____, willfully and voluntarily make known my desire that my dying not be artificiallyprolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and:

_____(initial) I have a terminal condition, or

_____(initial) I have an end stage condition, or

_____(initial) I am in a persistent vegetative state, and if my primary physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such a condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such 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.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name:_____

Address:_____

_____

Phone: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):

(Signed) _____

Witness Signatures:

Witness:_____

Printed Name:_____

Address:_____

_____

Phone: _____

Witness:_____

Printed Name:_____

Address:_____

_____

Phone: _____

At least one witness must not be a husband or wife or a blood relative of the principal.