DESIGNATION OF HEALTH CARE SURROGATE*[
(AND HIPAA RELEASE AUTHORIZATION)]*

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

Name: [line/text]

Address: [line/text]

Phone: [line/text]

The determination of whether I have become incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures shall be certified in writing by my physician.*[

RESTRICTIONS

_____]*

*[**DESIGNATION OF ALTERNATE SURROGATE**

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate the following person[s] as my surrogate[s] to make health care decisions for me as authorized by this document*[, and they shall serve in the following order]*:

*[A. First Alternate Surrogate

]*

Name: [line/text]

Address: [line/text]

Phone: [line/text]

*[B. Second Alternate Surrogate

Name: [line/text]

Address: [line/text]

Phone: [line/text]

*[C. Third Alternate Surrogate

Name: [line/text]

Address: [line/text]

Phone: [line/text]

*[D. Fourth Alternate Surrogate

Name: [line/text]

Address: [line/text]

Phone: [line/text]

]*

ADDITIONAL INSTRUCTIONS

I hereby require my surrogate to direct my physicians to comply with any valid Living Will, Directive to Physicians, or similar document which I may have heretofore executed or which I may hereafter execute. My surrogate is not authorized to direct my physician in a manner which would contradict any such valid Living Will, Directive to Physicians, or similar document.*[

A surrogate serving hereunder shall be treated as having resigned as my surrogate if such surrogate refuses to arrange for or submit to a mental status examination requested by any [HIPAA language], the purpose of which is to determine whether such surrogate should be permitted to continue to serve as my surrogate hereunder, provided that such examinations shall not occur more frequently than once every two years, and provided further that the cost of such examinations shall be paid by me.]*

My surrogate shall have full power and authority to make all health care decisions for me during my incapacity as if I were able to make such decisions myself. In particular, and without limiting my surrogate's authority, my surrogate shall have the following powers:

1. The power to consult expeditiously with appropriate health care providers to provide informed consent, including written consent on an appropriate form, to any medical procedure;

2. The power to make health care decisions for me which my surrogate believes I would have made under the circumstances if I were capable of making such decisions;

3. The power to apply for public benefits, such as Medicare and Medicaid, for me, and to have access to information regarding my income, assets, banking records, and financial records as required to make such application;

4. The power to authorize the release of information and clinical records to appropriate persons to ensure the continuity of my health care; and

5. The power to authorize the transfer and admission of me to or from a health care facility.

Definitions

The following definitions as set forth in Section 765.101 of the Florida Statutes shall apply:

1. "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 all records of the principal reasonably necessary for a health care surrogate to make decisions involving health care and to apply for benefits.

d. The decision to make an anatomical gift pursuant to part V of chapter 765 of the Florida Statutes.

2. "Health care facility" means a hospital, nursing home, hospice, home health agency, or health maintenance organization licensed in this state, or any facility subject to part I of chapter 394.

3. "Health care provider" or "provider" means any person licensed, certified, or otherwise authorized by law to administer health care in the ordinary course of business or practice of a profession.

4. "Incapacity" means the patient is physically or mentally unable to communicate a willful

and knowing health care decision. For the purposes of making an anatomical gift, the term also includes a patient who is deceased.

5. "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.

6. "Life-prolonging procedure" means any medical procedure, treatment, or intervention, including artificially provided sustenance and hydration, which sustains, restores, or supplants a spontaneous vital function. The term does not include the administration of medication or performance of medical procedure, when such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.

7. "Living will" means:

a. A witnessed document in writing, voluntarily executed by the principal in accordance with Florida Statute 765.302; or

b. A witnessed oral statement made by the principal expressing the principal's instructions concerning life-prolonging procedures.

8. "Physician" means a person licensed pursuant to chapter 458 or chapter 459 of the Florida Statutes.

9. "Principal" means a competent adult executing an advance directive and on whose behalf health care decisions are to be made.

10. "Surrogate" means any competent adult expressly designated by a principal to make health care decisions on behalf of the principal upon the principal's incapacity.*[

HIPAA RELEASE AUTHORITY

I intend for my surrogate to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164. This release authority is effective immediately.

Accordingly, I hereby authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health-care professional, dentist, optometrist, health plan, hospital, hospice, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, pathologist, or other provider of

medical or mental health care, as well as any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has paid for or is seeking payment from me for such services, to give, disclose and release to my surrogate who is named herein and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. Additionally, my surrogate shall have the ability to ask questions and discuss my protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to any protected medical information to my surrogate. Such information may also be released to any person designated as a primary or successor agent or attorney-in-fact in a durable power of attorney which I have executed, whether or not such person is presently serving as such, and to any person presently serving as trustee or named as a successor trustee in any revocable or irrevocable trust created by me as [grantor/settlor/trustor].

In determining whether I am incapacitated, all individually identifiable health information and medical records shall be released to the person who is nominated as my surrogate hereunder, including any written opinion relating to my incapacity that the person nominated as my surrogate may have requested. This release authority applies to any information governed by HIPAA and applies even if that person has not yet begun serving as my surrogate.

This authority given to my surrogate shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to my surrogate may be subject to redisclosure by my surrogate and may no longer be protected by HIPAA. The authority given to my surrogate herein has no expiration date and shall expire only in the event that I revoke this Designation of Health Care Surrogate in writing and deliver it to my health-care provider. There are no exceptions to my right to revoke this Designation of Health Care Surrogate.]*

DURATION*[

I understand that this Designation of Health Care Surrogate exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the Designation of Health Care Surrogate. If I am unable to make health care decisions for myself when this Designation of Health Care Surrogate expires, the authority I have granted my surrogate continues to exist until the time I become able to make health care decisions for myself.]**[

This Designation of Health Care Surrogate ends on the following date: _____]*

PRIOR DESIGNATIONS REVOKED

I revoke any prior Designation of Health Care Surrogate or similar document.

I fully understand that this designation will permit my designee to make health care decisions 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.

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: _____

I sign my name to this Designation of Health Care Surrogate on _____, [year], at _____ County, Florida.

_____

_____, Principal

[[Witness sig for Ack where Notary signs - I]]

SIGNATURE OF FIRST WITNESS

The Principal signed the foregoing Designation of Health Care Surrogate in my presence. I am not the person appointed as surrogate by this document. I am an adult, and I am not the spouse nor a blood relative of _____.

Witness Signature: _____

Print Name: *[_____]**[_____]*

Address: *[_____]**[_____]*

Phone: _____

Date: _____, [year]

SIGNATURE OF SECOND WITNESS

The Principal signed the foregoing Designation of Health Care Surrogate in my presence. I am not the person appointed as surrogate by this document. I am an adult, and I am not the spouse nor a blood relative of _____.

Witness Signature: _____

Print Name: *[_____]**[_____]*

Address: *[_____]**[_____]*

Phone: _____

Date: _____, [year]

*[

[Indiv's Long][

THE STATE OF [STATE] §

§

COUNTY OF _____ §

Before me, the undersigned authority, on this day personally appeared _____, [Identity of Individual in Ack] to be the person whose name is subscribed to the foregoing instrument as Principal, *[*[_____,]**[_____,]*[Identity of Witnesses in Ack],]*and *[*[_____,]**[_____,]*[Identity of Witnesses in Ack], each of whom]*acknowledged to me that such Principal executed the foregoing instrument *[in the presence of such witnesses, who signed as witnesses,]*for the purposes and consideration therein expressed.

Given under my hand and seal of office, on _____, [year].

_____

Notary Public, State of [State][Notary line]

]****[Indiv's Short]****[**

THE STATE OF [STATE] §

§

COUNTY OF _____ §

This instrument was acknowledged before me on _____, [year], by _____*[, *[_____,]**[_____,]*and *[_____]**[_____]*]*.

_____

Notary Public, State of [State][Notary line]

]****[Indiv Outside US before Consular Official]****[**

_____ §

§

_____ §

Before me, the undersigned authority, _____ (insert title), of the United States of America at _____ (insert city and country), duly commissioned, accredited, and qualified on this day personally appeared _____, [Identity of Individual in Ack] to be the person whose name is subscribed to the foregoing instrument as Principal, *[*[_____,]**[_____,]*[Identity of Witnesses in Ack],]*and *[*[_____,]**[_____,]*[Identity of Witnesses in Ack], each of whom]*acknowledged to me that such Principal executed the foregoing instrument *[in the presence of such witnesses, who signed as witnesses,]*for the purposes and consideration therein expressed.

Given under my hand and seal of office, on _____, [year].

_____

Signature of Officer

Printed name: _____

Rank: _____

Title of officer: _____

]****[Notary signs for Indiv]****[

THE STATE OF [STATE] §

§

COUNTY OF _____ §

Before me, the undersigned authority, on this day personally appeared _____, a person having a physical impairment that impedes *[his]**[her]*ability to sign the foregoing instrument, [Identity of Individual in Ack] to be the person named in the foregoing instrument as Principal, and directed me to affix *[his]**[her]*signature to the foregoing instrument*[in the presence of *[_____,]**[_____,]*[Identity of Witnesses in Ack]]*, and *[*[_____,]**[_____,]*[Identity of Witnesses in Ack], each of whom]*acknowledged to me that such Principal directed me to execute the instrument on *[his]**[her]*behalf *[in the presence of such witnesses, who signed as witnesses,]*for the purposes and consideration therein expressed.

Given under my hand and seal of office, on _____, [year].

_____

Notary Public, State of [State][Notary line]

]****[Indiv Sign With Mark]****[**

THE STATE OF [STATE] §

§

COUNTY OF _____ §

Before me, the undersigned authority, on this day personally appeared _____, [Identity of Individual in Ack] to be the person whose mark is made on the foregoing instrument as Principal, *[*[_____,]**[_____,]*[Identity of Witnesses in Ack],]*and *[*[_____,]**[_____,]*[Identity of Witnesses in Ack], each of whom]*acknowledged to me that such Principal executed the foregoing instrument *[in the presence of such witnesses, who signed as witnesses,]*for the purposes and consideration therein expressed.

Given under my hand and seal of office, on _____, [year].

_____

Notary Public, State of [State][Notary line]

]****[Attorney in Fact Signing For Indiv - Long Form]****[**

THE STATE OF [STATE] §

§

COUNTY OF _____ §

Before me, the undersigned authority, on this day personally appeared _____, personally known to me or who has produced _____ (type of identification) as identification, whose name is subscribed to the foregoing instrument as the attorney-in-fact of _____, Principal, and *[also on this day personally appeared *[_____,]**[_____,]*[Identity of Witnesses in Ack], and *[_____,]**[_____,]*[Identity of Witnesses in Ack], each of whom]*acknowledged to me that such attorney-in-fact subscribed the name of _____ to such instrument on behalf of _____ and as the attorney-in-fact of _____ in such attorney-in-fact's own name *[in the presence of such witnesses, who signed as witnesses,]*for the purposes and consideration therein expressed.

Given under my hand and seal of office, on _____, [year].

_____

Notary Public, State of [State][Notary line]

]****[Attorney-In-Fact Signing For Indiv - Short Form]****[**

THE STATE OF [STATE] §

§

COUNTY OF _____ §

This instrument was acknowledged before me on _____, [year], by _____ (insert name of attorney-in-fact) as attorney-in-fact on behalf of _____*[, and by *[_____,]**[_____,]*and *[_____]**[_____]*]*.

_____

Notary Public, State of [State][Notary line]

]*]**[

SEPARATE HIPAA RELEASE AUTHORITY

I intend for my surrogate to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164. This release authority is effective immediately.

Accordingly, I hereby authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health-care professional, dentist, optometrist, health plan, hospital, hospice, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, pathologist, or other provider of medical or mental health care, as well as any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has paid for or is seeking payment from me for such services, to give, disclose and release to my surrogate who is named in the attached Designation of Health Care Surrogate and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. Additionally, my surrogate shall have the ability to ask questions and discuss my protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to any protected medical information to my surrogate.

Such information may also be released to any person designated as a primary or successor agent or attorney-in-fact in a durable power of attorney which I have executed, whether or not such person is presently serving as such, and to any person presently serving as trustee or named as a successor trustee in any revocable or irrevocable trust created by me as [grantor/settlor/trustor].

In determining whether I am incapacitated, all individually identifiable health information and medical records shall be released to the person who is nominated as my surrogate in the attached Designation of Health Care Surrogate, including any written opinion relating to my incapacity that the person nominated as my surrogate may have requested.

This release authority applies to any information governed by HIPAA and applies even if that person has not yet begun serving as my surrogate.

This authority given to my surrogate in the attached Designation of Health Care Surrogate shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information.

The individually identifiable health information and other medical records given, disclosed, or released to my surrogate in the attached Designation of Health Care Surrogate may be subject to redisclosure by my surrogate and may no longer be protected by HIPAA.

The authority given to my surrogate in the attached Designation of Health Care Surrogate has no expiration date and shall expire only in the event that I revoke the Designation of Health Care Surrogate in writing and deliver it to my health-care provider.

There are no exceptions to my right to revoke the Designation of Health Care Surrogate.

Date: _____, [year].

_____

SIGNATURE OF FIRST WITNESS

Witness Signature: _____

Print Name: *[_____]**[_____]*

Address: *[_____]**[_____]*

Date: _____, [year]

SIGNATURE OF SECOND WITNESS

Witness Signature: _____

Print Name: *[_____]**[_____]*

Address: *[_____]**[_____]*

Date: _____, [year]

*[
[Witness sig for Ack where Notary signs - I]]*]**[

DESIGNATION OF HEALTH CARE SURROGATE*[
(AND HIPAA RELEASE AUTHORIZATION)]*

OF

_____

Prepared by:

_____
_____
_____, _____ _____

_____
_____ (facsimile)]*