DESIGNATION OF HEALTH CARE SURROGATE

I, _____, of _____ County, Florida, hereby enter into this Designation of Health Care Surrogate.

1. In the event that I have been determined to be incapacitated to provide informed consent for medical treatment, surgical or diagnostic procedures, I designate the following as my surrogates:

    1. _____, presently residing at

    _____

    _____

    _____(PHONE)

    2. _____, presently residing at

    _____

    _____

    _____(PHONE)

2. I fully understand that this designation will permit my surrogate 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.

3. Specifically, my surrogate shall:

    (a) Have authority to act for me and to make all health care decisions for me in matters regarding my health care during my incapacity.

    (b) Consult expeditiously with appropriate health care providers to provide informed consent in my best interests, and to make only my health care

decisions which my surrogate believes I would have made under the circumstances if I were capable of making such decisions.

(c) Provide written consent using an appropriate form whenever consent is required, including, but not limited to, a physician's order not to resuscitate.

(d) Be provided access to all my medical records, including, but not limited to notes, x-rays, test results and reports.

(e) Apply for public benefits, such as Medicare and Medicaid, for me and have access to information regarding my income and assets in banking and financial records to the extent required to make application. A health care provider or facility may not, however, make such application a condition of continued care if I, if capable, would have refused to apply.

4. In the event of disability resulting in loss of speech and/or movement, I request that a qualified speech pathologist and occupational therapist be assigned to set a system for augmentation communication to be able to effectively communicate.

5. My surrogate may discuss pain management and palliative care with my attending or treating physician, or such physician's designee, when my surrogate is discussing the diagnosis, planned course of treatment, alternatives, risks, or prognosis for my illness.

6. My surrogate may authorize the release of information and medical records to appropriate persons to insure the continuity of my health care.

7. My surrogate may determine my residence, on a permanent or temporary basis, and may authorize the transfer or admission of me to and from a health care facility.

8. To the extent of any inconsistency between the provisions of this instrument and any power of attorney I may have exercised, the provisions of this instrument shall prevail. To the extent of any inconsistencies between the provisions of this instrument and the provisions of a declaration regarding withdrawal of life-prolonging procedures or Living Will, the provisions of the declaration shall prevail.

9. If, after the appointment of my surrogate, a court appoints a guardian of my property or a guardian of my person or any other fiduciary charged with the management of my property, my surrogate shall continue to make health care decisions for me. My surrogate may report my health care status to any such guardian.

10. If I am required to enter a health care facility, it is my desire to return to my residence upon leaving such health care facility.

11. In addition to all other powers granted by this document, I grant to my surrogate the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996 and its regulations ("HIPAA")

during any time my health care representative is exercising authority under this document.

Pursuant to HIPAA, I specifically authorize my surrogate as my HIPAA personal representative to request, receive and review any information regarding my physical or mental health, including, without limitation all HIPAA protected health information, medical and hospital records; to execute on my behalf any authorizations, release or other documents that may be required in order to obtain this information; and to consent to the disclosure of this information. I further authorize my surrogate to execute on my behalf any documents necessary or desirable to implement the health care decisions that my surrogate is authorized to make under this document.

By signing this Designation of Health Care Surrogate, I specially empower and authorize my physician, hospital or health care provider to release any and all medical records to my surrogate's designee. Further, I waive any liability to any physician, hospital or any health care provider who releases any and all of my medical records to my surrogate.

The authority given my agent 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 authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

12. Definitions:

(a) "Health care decision" means informed consent, refusal of consent, or withdrawal of consent to health care, and includes the decision to apply for public benefits to defray the cost of health care.

(b) "Health care facility" means a hospital, nursing home, or hospice licensed in the state in which it is located.

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

(d) "Incapacity to consent" means the patient's judgment is so affected by a physical or mental condition that he or she lacks the ability to communicate a willful and knowing health care decision either physically or verbally as determined by the client's attending physician or another physician and the named health care surrogate.

(e) "Informed consent" means consent voluntarily given by a person, after sufficient explanation and disclosure of the subject matter involved to enable him or her to have a general understanding of the procedure and the medically acceptable alternative procedures and to make a knowing health care decision without duress or coercion.

13. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

Executed this ____day of _____, 20___.

_____ [signature]

_____, Principal [printed name]

We saw _____, in our presence, sign this instrument at its end; He/she is known to us and we believe him/her to be of sound mind and memory and not under duress or constraint of any kind; and neither of us is a spouse, a blood relative, an heir to his/her estate, or responsible for paying his/her health care costs.

_____ _____
Signature of Witness Signature of Witness

_____ _____
Printed Name of Witness Printed Name of Witness

STATE OF FLORIDA
COUNTY OF _____

The foregoing instrument was acknowledged before me this ____ day of _____, 20_____, by_____ who [ ] is personally known to me or who [ ] has produced _____, as identification and who did not take an oath.

_____
Notary Public
Print Name:

My commission expires: