DESIGNATION OF HEALTH CARE SURROGATE

Name:

In the event that I have been determined to be incapacitated and/or incompetent to provide informed consent or to withhold for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name:
Address:
Phone:

If surrogate listed above is unavailable, unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name:
Address:
Phone:

I fully understand that this designation will permit my designee 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.

Additional instructions *(optional): I have executed a Living Will. Please refer to that document as needed*.

I have executed a Living Will requesting life prolonging procedures to be withheld or withdrawn pursuant to Florida Statutes 765.101 – 765.404 (2012), or its subsequent Statutes. My health care surrogate designated herein is hereby authorized to consent to the withholding or withdrawing of life prolonging procedures for me pursuant to Florida Statutes 765.101 – 765.404 (2012), or its subsequent statutes.

Health Insurance Portability and Accountability Act (HIPAA): For the purposes of accessing, reviewing and releasing my health care information and any other protected information pursuant to HIPAA, my health care surrogate or my alternative health care surrogate shall be considered my "Personal Representative" for purposes of compliance with Federal HIPAA (Health Insurance Portability and Accountability Act) Laws and regulations and this designation shall become effective immediately upon the execution of this instrument and shall not be contingent upon my inability to make health care decisions or to provide informed consent. My Health Care Surrogate shall have access to any and all medical records, medical history, billing and any other information related to my medical care. Further, I authorize my Health Care Surrogate to execute releases

of such confidential information in my place and stead. All third parties, including insurance companies, physicians, pharmacists, healthcare facilities, clinics, hospitals, and all other providers of my medical care shall comply with my Healthcare Surrogate's request for information and accept any releases executed by the Healthcare Surrogate. I specifically direct that the Florida Statute concerning Healthcare Surrogates as effective on the date this document is presented shall supercede any language in HIPAA Federal Laws and Regulations related to disclosure that would place limitations on my Healthcare Surrogate's access to my medical information and decision-making.

My health care surrogate may also:

- Expeditiously consult with appropriate health care providers to provide informed consent in my best interest and 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;

- Give my consent in writing using the appropriate consent forms.

- Have full and complete authority and access to all of my healthcare information and to have authority to authorize the release of information and clinical records to appropriate persons to ensure the continuity of my health care;

- Authorize my transfer and admission to or from a health care facility;

- Continue to make health care decisions, even if, after the appointment of my Surrogate, a Court appoints a guardian of my estate or other fiduciary charged with the management of my property, unless the Court removes the powers provided to my Surrogate herein.

Other parties: No private government entity shall have any control, influence or direction over the decision of my designated surrogate.

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: _____
_____
_____

Signed: _____

Date: _____, 2014

We, the witnesses, are over the age of 18 years and are not related to the Declarant. The Declarant signed this document in our presence at the date above and we also signed on the date above.

Witness:_____

Witness:_____