DESIGNATION OF HEALTH CARE SURROGATE — State of Florida

State of Florida

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I, _____, residing at _____, being of sound mind, hereby appoint _____, residing at _____ (Phone: _____, Email: None), as my primary Health Care Agent to make all medical decisions on my behalf if I am unable to make them myself.

ALTERNATE AGENT: If my primary agent is unable, unwilling, or ineligible to serve, I appoint _____, residing at _____ (Phone: _____), as my alternate Health Care Agent.

EFFECTIVE TRIGGER & AGENT AUTHORITY

EFFECTIVE TRIGGER & AUTHORITY: This directive shall become effective only if my attending physician determines that I lack the capacity to make or communicate my own healthcare choices. My agent shall have full authority to request, receive, review, and consent to or refuse any medical treatment, surgical procedures, diagnostic tests, or medication, and to inspect my medical records in compliance with HIPAA regulations.

LIFE-SUSTAINING TREATMENT CHOICES

LIFE-SUSTAINING TREATMENT: My agent shall have full and absolute authority to make all decisions regarding life support, artificial nutrition, and hydration, consistent with what they believe are my values and best interests.

STATE-REQUIRED PROVISIONS

FLORIDA DESIGNATION OF HEALTH CARE SURROGATE (FLA. STAT. § 765.202): THE PRINCIPAL DESIGNATES A HEALTH CARE SURROGATE TO MAKE MEDICAL CHOICES. MUST BE SIGNED IN THE PRESENCE OF TWO SUBSCRIBING ADULT WITNESSES, AT LEAST ONE OF WHOM IS NEITHER A SPOUSE NOR A BLOOD RELATIVE. THE SURROGATE MAY NOT SERVE AS A WITNESS.

SIGNATURES

_____

Signature

Principal: _____

Date: _____

WITNESS DECLARATIONS

The undersigned witnesses hereby declare under penalty of perjury that the principal signed this document in our presence.

_____

Witness 1 Signature

Name: _____

Address: _____

Date: _____

_____

Witness 2 Signature

Name: _____

Address: _____

Date: _____