DESIGNATION OF HEALTH CARE SURROGATE of _____, Principal

I, _____, currently residing at _____ do hereby create the following designation of health care surrogate:

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

Name: _____

Address: _____

Phone: _____

If the 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; and to obtain my medical records from any health care provider, including all records subject to regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and subsequent amendments to that Act.

_____ I have executed a Living Will requesting life prolonging procedures to be withheld or withdrawn pursuant to Florida Statutes Sections 765.101 - 765.304 (or subsequent). 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 and 765.304 - .305 (or subsequent) and any other applicable statutes. Please refer to that document as needed.

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 under HIPAA and have the full and complete authority to access, review, and/or release any and all of my health care information and any other protected information.

OTHER PARTIES: No private or government entity shall have any control, influence, or direction of the decisions of my designated surrogate.

I authorize and designate my health surrogate to execute my death certificate and sign any documents required by the funeral director on my behalf to finalize my funeral arrangements. For this purpose, my health surrogate shall be my "legally authorized person" as defined in Florida Statute Section 497.005(39).

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____.

Signed: _____
Principal

The foregoing Designation of Health Care Surrogate was signed by the Principal in the presence of the Witnesses, **both of whom are adults and neither of whom is the spouse or a blood relative of the Principal**.

Witness Signature: _____

Printed Name: _____

Address: _____

Witness Signature: _____

Printed Name: _____

Address: _____