

OF

1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
2. Apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.
3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
4. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.

SPECIFIC INSTRUCTIONS AND RESTRICTIONS

(initial here) 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.

(initial here) My surrogate may provide consent for abortion, sterilization, electroshock therapy, psychosurgery, experimental treatments that have not been approved by a federally approved institutional review board in accordance with 45 C.F.R. part 46 or 21 C.F.R. part 56, or voluntary admission to a mental health facility.

(initial here) My surrogate may provide consent for the withholding or withdrawing of life-prolonging procedures as long as my unborn child or children are not considered viable as defined in Section 390.011 of the Florida Statutes.

While I have decision-making capacity, my wishes are controlling and my physicians and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.

To the extent I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

THIS HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES.

PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND THIS DESIGNATION BY:

- (1) SIGNING A WRITTEN AND DATED INSTRUMENT WHICH EXPRESSES MY INTENT TO AMEND OR REVOKE THIS DESIGNATION;
- (2) PHYSICALLY DESTROYING THIS DESIGNATION THROUGH MY OWN ACTION OR BY THAT OF ANOTHER PERSON IN MY PRESENCE AND UNDER MY DIRECTION;
- (3) VERBALLY EXPRESSING MY INTENTION TO AMEND OR REVOKE THIS DESIGNATION; OR
- (4) SIGNING A NEW DESIGNATION THAT IS MATERIALLY DIFFERENT FROM THIS DESIGNATION.

MY HEALTH CARE SURROGATE'S AUTHORITY BECOMES EFFECTIVE WHEN MY PRIMARY PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN HEALTH CARE DECISIONS UNLESS I INITIAL EITHER OR BOTH OF THE FOLLOWING BOXES:

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IF I INITIAL THIS BOX, MY HEALTH CARE SURROGATE'S AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECT IMMEDIATELY.

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IF I INITIAL THIS BOX, MY HEALTH CARE SURROGATE'S AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME TAKES EFFECT IMMEDIATELY. PURSUANT TO SECTION 765.204(3), FLORIDA STATUTES, ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY SHALL SUPERSEDE ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE THAT ARE IN MATERIAL CONFLICT WITH THOSE MADE BY ME.

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 (referred to herein as a "covered entity"), to give, disclose and release to my surrogate who is named herein, 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 settlor.

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. I authorize my agent to bring a legal action against a covered entity which refuses to accept and recognize this release authority. No covered entity may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR 164.508(b)(4) applies. Further, in order to fulfill my intent as expressed herein, I authorize my agent to sign any documentation that my agent deems necessary or appropriate in order to secure the disclosure of my individually identifiable health information and other medical records. Any information disclosed to my agent may subsequently be disclosed to another party by my agent. My agent shall not be required to indemnify a covered entity or perform any act in the event information is subsequently disclosed by my agent. 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.

PRIOR DESIGNATIONS REVOKED

Notary Public

DESIGNATION OF HEALTH CARE SURROGATE AND HIPAA RELEASE AUTHORIZATION

OF

{APPLICANT'S NAME}

Prepared by:

{Name Of Attorney}

{Address Of Attorney's Office}

{Attorney's Office Phone Number}

