

Declaration of Medical Proxy

Under Florida Statute 765.401, a medical proxy can be appointed to make health care decisions for an “incapacitated or developmentally disabled patient” if there is no executed advance directive, if there is no designated surrogate or alternate surrogate to execute an advance directive, or if the designated or alternate surrogate is no longer available to make health care decisions.

Health care decision means providing informed consent, refusal of consent or withdrawal of consent to any and all health care; decisions concerning private, public, government, or veteran’s benefits to defray the cost of health care and the right of access to all records of the principal reasonably necessary for a medical proxy to make decisions involving health care. Health care decisions may be made for the patient by any of the following individuals, in the following order of priority, if no individual in a prior class is reasonably available, willing, or competent to act. Please check the appropriate proxy category you are signing under:

- A court appointed guardian or guardian advocate;
- The patient’s spouse;
- An adult child of the patient or the majority thereof;
- A parent of the patient;
- An adult sibling of the patient or the majority thereof;
- An adult relative of the patient who has exhibited special care and concern for the patient;
- A close friend of the patient; or
- A licensed clinical social worker or a clinical social worker who is a graduate of a court-approved guardianship program selected by a bioethics committee.

The patient’s attending physician should evaluate the patient’s capacity and if the physician concludes the patient has capacity to make health care decisions, the attending physician should enter that evaluation in the patient’s record. If the attending physician questions capacity, a second physician can also be consulted.

I, _____, medical proxy, confirm that the above conditions have been met for the patient, _____, and that there are no available surrogates to be considered from a prior class according to this statute. Therefore, I accept the designation of Medical Proxy for the patient named above. I agree to make health care decisions based upon what I reasonably believe the patient would make under the circumstances. I accept the responsibilities of Medical Proxy as authorized under Florida Statute 765.401.

Medical Proxy Signature

Date

STATE OF FLORIDA

COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this ____ day of _____, _____, by

_____.

Notary Public Signature

Print, Type or Stamp Commissioned Name of Notary

Personally Known _____ OR Produced Identification _____ Type of Identification

Produced _____

