DESIGNATION OF HEALTH CARE SURROGATE

I, , hereby revoke any and all Designations
[*Print Name*]
heretofore made by me, and make this Designation on , .
[*Month and Day*] [*Year*]

In the event that I have been determined to be incapacitated 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: Home: Cell:

If my surrogate is unwilling or unable to perform these duties, I wish to designate as my alternate surrogate:

Name:

Address:

Phone: Home: Cell:

If my alternate surrogate is unwilling or unable to perform these duties, I wish to designate as my second alternate surrogate:

Name:

Address:

Phone: Home: Cell:

I fully understand that this designation will permit my designee to make health care decisions, except those specific decisions to be made by my surrogate under my living will, and 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

costs of health care; and to authorize my admission, discharge or transfer to or from a health care facility or other facility or program licensed under Chapter 400 of the Florida Statutes. I designate my health care surrogate as my personal representative under 45 CFR § 164.502(g), a portion of the regulations implementing the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), for all health care-related decisions.

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

_____

[*Sign Here*]

_____

Witness

_____

Witness

*Please note that a person designated as a surrogate cannot act as a witness, and at least one of the witnesses must be someone other than a spouse or a blood relative.