

**DURABLE HEALTH CARE POWER OF ATTORNEY
AND DESIGNATION OF HEALTH CARE SURROGATE**

Name: _____

In the event I have been determined to be incapacitated and therefore incapable of providing informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate the individual named below as my surrogate for health care decisions. In addition to the other powers granted by this document, my surrogate shall have the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, (Pub. L. 104-191), 45 CFR Section 160 through 164.

Name: _____

Address: _____

OR

Name: _____

Address: _____

I have discussed my wishes concerning medical care and my views regarding life-prolonging procedures with my surrogate(s) I have named. I may further document my desires regarding specific situations in which I would want treatment performed or withheld, for the use of my surrogate in making any health care decisions for me.

- A. I grant to said surrogate full power and authority to do and perform all and every act and thing whatsoever requisite, proper, or necessary to be done, in the exercise of the rights herein granted, as fully to all intents and purposes as I might or could do if personally present and able with full power of substitution or revocation, hereby ratifying and confirming all that said surrogate shall lawfully do or cause to be done by virtue of this declaration and the rights and power granted herein.
- B. In the event my attending physician concludes that I lack the capacity to make health care decisions for myself or provide informed consent, and another physician agrees that I lack such capacity, my said surrogate is authorized to:
 - 1. Have authority to act for me and to make all health care decisions for me in matters regarding my health care during my incapacity, in accordance with my instructions, unless I have expressly limited such authority.
 - 2. Authorize the entry of a Do Not Resuscitate (DNR) Order directed to any hospital, nursing home or other health care facility.

3. Consult expeditiously with appropriate health care providers to provide informed consent in my best interest and make only health care decisions for me which he or she believes I would have made under the circumstances if I were capable of making such decisions.
 4. Provide written consent using an appropriate form whenever consent is required.
 5. Be provided access to my appropriate medical records.
 6. Apply for public benefits, such as Medicare and Medicaid, for me, and have access to information regarding my income and assets and banking and financial records to the extent required to make application.
 7. My surrogate may authorize the release of information and clinical records to appropriate persons to ensure the continuity of my health care and may authorize my transfer and admission to or from a health care facility.
 8. Submit on my behalf any claims or documentation required to any private insurance company with which I may have an effective policy for medical care benefits.
 9. Authorize or refuse to authorize any pain-killing medication or surgical or medical procedures of any kind intended to relieve pain which my surrogate determines may be helpful even though such medications or procedures may lead to permanent damage, addiction or hasten my death.
 10. Grant any waivers or releases to health care providers, hospital staff, physicians, nurses and other medical or hospital administrative personnel who act in reliance on instructions as given by my surrogate from all liability for damages suffered or to be suffered by me.
 11. Exercise my right of privacy and my right to participate in decisions regarding any of my medical care even if the exercise of such rights might hasten my death.
 12. Take such legal action in my name as my surrogate deems necessary and at the expense of my estate to force compliance with my wishes as determined by my surrogate; to seek actual or punitive damages against any person, organization or other entity who negligently or willfully fails or refuses to follow such instructions.
 13. Take any action not specifically described above necessary to carry out the intent of this document.
- C. If at any time I have a terminal condition, an end-stage condition, or I am in a persistent vegetative state and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. I specifically exonerate and hold my physicians harmless for any liability which may otherwise result from rendering such opinion.

A terminal condition, defined in Florida Statute 765.101 (17), is “a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.”

An end-stage condition, defined in Florida Statute 765.101 (4), is “an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively

severe and permanent deterioration, and for which, to a reasonable degree of medical probability, treatment of the irreversible condition would be ineffective.”

A persistent vegetative state, defined in Florida Statute 765.101 (12 a, b), is a “permanent and irreversible condition of unconsciousness in which there is: (a) the absence of voluntary action or cognitive behavior of any kind, (b) an inability to communicate or interact purposefully with the environment.”

If I am in any terminal condition, end-stage condition, or persistent vegetative state, it is my intent to fully withhold or withdraw life-prolonging procedures including but not limited to:

Electrical, mechanical or chemical resuscitation of my heart when it has stopped beating.

Nasogastric tube feeding, or any other form of artificial hydration or nutrition, when I am paralyzed or unable to take nourishment or hydration by mouth.

Mechanical respiration when I am no longer able to sustain my own breathing.

Such other procedures that would have the effect of prolonging life.

- D. I also direct my said surrogate to make arrangements for the treatment of my terminal condition, end-stage condition, or persistent vegetative state under the auspices of a hospice, if I should qualify for such care. I understand that acceptance into hospice care entails foregoing curative treatment and life-sustaining procedures that might otherwise be performed, such as resuscitation in case of cardiac arrest, and that foregoing such procedures might hasten my dying. I hereby consent to hospice care under such conditions, and direct my surrogate to make any and all necessary arrangements for me to receive such care, including the signing of such consent forms as may be required by the hospice, any third party payor, and the Federal government.
- E. In the absence of my ability to give directions regarding my health care, it is my intention that my said surrogate shall exercise this specific grant of authority and that such exercise shall be honored by my family, physicians, nurses, and any health care facilities in which I may be treated (including ambulances by which I may be conveyed between my residence and a health care facility), as the final expression of my legal rights to refuse medical or surgical treatment. I understand and accept the consequences of such refusal.
- F. In order to induce all health care providers, physicians, health care facilities, any other persons or organizations or entities, or any other party to act in reliance upon this Designation and in accordance with the instructions of my surrogate, I hereby represent, warrant and agree that if this Designation is revoked or amended for any reason, then I, my estate, my heirs, beneficiaries, successor or assigns agree to hold any such health care provider, health care facility, physician or any other person, organization or entity harmless from any loss suffered or liability incurred as a result of the instructions of my surrogate prior to the receipt by such person, corporation or entity of actual notice of the revocation or amendment of this Designation. No person who acts in good faith upon any representation, direction, decision or any act of my surrogate shall be liable to me, my estate or my heirs or assigns for recognizing my surrogate's authority.
- G. If, after the appointment of my surrogate, a court appoints a guardian of my estate, or my person, or any other fiduciary charged with the management of my property, my surrogate shall continue to make health care decisions for me. My surrogate may report my health care status to the guardian.

- H. I specifically provide that my surrogate shall not be held civilly or criminally liable for any acts or decisions that shall be made in accordance with the terms and instructions of this Designation if my surrogate shall act as a reasonably prudent person in accordance with the instructions in this Designation.
- I. I understand the full significance of this Declaration and I am emotionally and mentally competent to designate a surrogate to make health care decisions for me in the event I am incapable of making such decisions or providing informed consent.
- J. I hereby revoke all prior Designations of Surrogate that I may have executed and I retain the right to revoke or amend this Designation and to substitute other surrogates. Amendments of this instrument shall be made in writing by me personally and shall be attached to the original of this Designation.
- K. This designation shall be governed by the laws of the State of Florida in all respects including its validity, construction, interpretation and termination. It is my intention and desire that this Designation of Surrogate be honored in any jurisdiction where it may be presented or where I may be found.

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

 Yes No. At the time of my death, should my attending physician determine that any part or organ of my body might be of use in preserving the life or quality of life of another person, I authorize and direct my physician to utilize such part or organ of my body for such purpose as will accomplish these ends.

The rights, powers, and authority of said surrogate herein granted shall commence and be in full force and effect from the date hereof and such rights, power and authority shall remain in full force and effect thereafter until this Declaration of Surrogate or any part thereof is revoked or amended by means sufficient under applicable state law to cause revocation or amendment.

Executed _____

Sign _____

Address _____

The undersigned hereby attest to their belief that the principal, _____ was of sound mind when he signed this Designation of Health Care Surrogate. We further attest that

neither of us is named as a surrogate in this Designation of Health Care Surrogate and that at least one of us is not the principal's spouse or blood relative.

Witness _____

Witness _____

Address _____

Address _____

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me on _____ by _____, who is personally known to me or who has produced _____ as identification.

NOTARY PUBLIC:

NOTARY SEAL:

Sign _____

Print _____

My Commission Expires _____

Commission Number _____