Designation of a Health Care Surrogate

Please indicate below who you trust to speak on your behalf if needed:

I, (Print name)_____**(Date of Birth)**___/___/___ **designate as my health care surrogate:**

Primary Health Care Surrogate Name: _____

Address: _____ **Phone:** _____ **Relationship:** _____

If my healthcare surrogate named above is not willing, able, or available to perform his or her duties, I designate as my alternate healthcare surrogate:

Alternate Health Care Surrogate Name: _____

Address: _____ **Phone:** _____ **Relationship:** _____

I authorize my health care surrogate to:

_____ (Initial Here) Receive health information whether oral or recorded in any form or medium, that:

1. Is created or received by a health care provider, health care facility, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; AND
2. Relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

I further authorize my health care surrogate to:

_____ (Initial Here) Make all health care decisions for me, which means he or she has the authority to:

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.

_____ (Initial here) Specific instructions and restrictions: _____

While I have decision-making capacity, my wishes come first 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.

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 one or both of the following, to be effective immediately**:

_____ (Initial Here) To receive my health care information.

_____ (Initial Here) To make my health care decisions for me, **as long as they do not conflict with the health care decisions I have made.**

- **I may make changes to my advance directives at any point by (1) completing and signing new forms which will automatically cancel any previous forms, (2) signing a statement or verbally stating my intent to materially change my current advance directive document, or (3) verbally expressing my intent to destroy, physically destroying, or instructing someone else to destroy, my advance directive document.**

PATIENT'S SIGNATURE: _____ **Date:** _____/_____/20_____

Print Name: _____ **Address:** _____

SIGNATURES OF WITNESSES:

First witness:
Print Name: _____
Address: _____
Signature: _____
Date: _____/_____/ 20_____

Second witness:
Print Name: _____
Address: _____
Signature: _____
Date: _____/_____/ 20_____

[18 years or older and not named as a surrogate. At least one of the witnesses must not be related by blood nor be the patient's spouse.]

Designation of a Health Care Surrogate

This health care surrogate designation form will help the healthcare team speak to the person you trust to speak on your behalf when you are no longer able to effectively participate in decision-making for yourself.

- It is a good idea to give copies to your health care surrogate(s) and/or physicians.
- Please discuss your health care wishes with whomever you name as your surrogate(s)
- You may revoke (destroy or cancel) an advance directive at any time.

Instructions: This will be your legal advance directive document designating your health care surrogate(s) once it is:

[ ] filled out,

[ ] signed by you,

[ ] dated,

[ ] and witnessed by two people 18 years or older and not named as a surrogate. At least one of the witnesses must not be related by blood nor be the patient's spouse.

Cleveland Clinic
Florida

V1.10.2020

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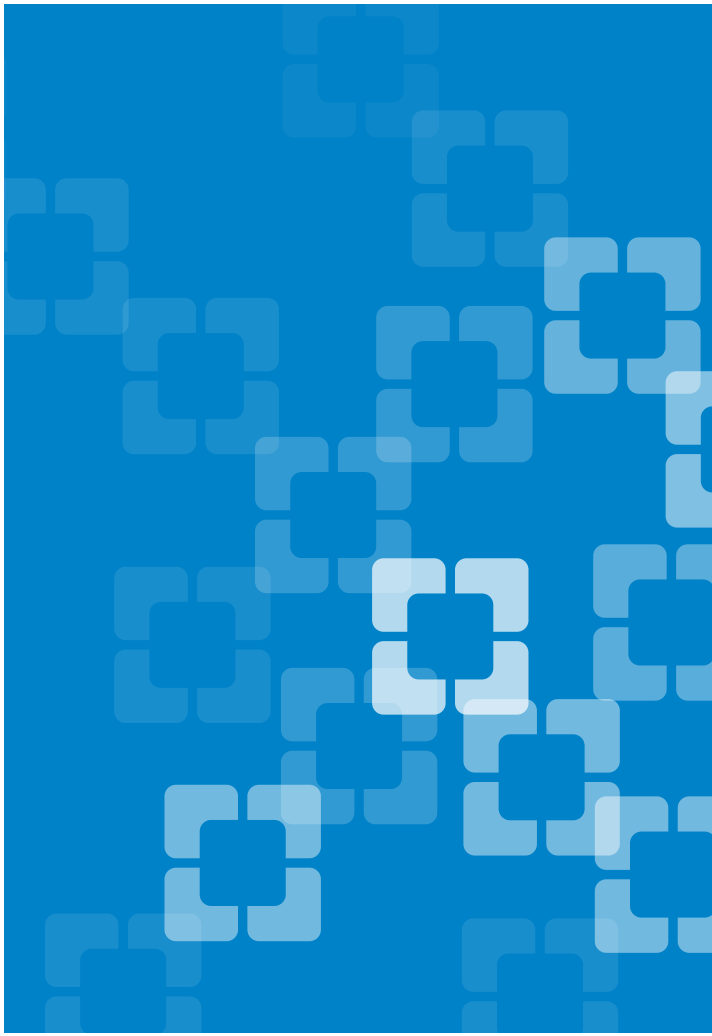

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