APPOINTMENT of HEALTHCARE SURROGATE

I, _____, want to choose how I will be treated by my healthcare
PRINT NAME
providers. In the event that I am unable or unwilling to communicate or I am incapable of making my decisions about receiving, withholding or withdrawing medical procedures or other treatments, I designate my healthcare surrogate (HCS) to make choices for me according to his/her understanding of my choices and values.

In the event that I am unable to communicate or make my medical decisions, my HCS may:

- Talk to my healthcare providers and have access to my medical information
- Authorize my treatment or have it withdrawn based on my choices
- Authorize transportation to another facility
- Make decisions regarding organ/tissue donation based on my choices
- Apply for public benefits, such as Medicare/Medicaid, on my behalf

CHOOSE A HEALTHCARE SURROGATE (HCS)

My Appointed HCS

Name:_____

Address:_____

Phone:_____ Alternate phone:_____

Email:_____

Alternate HCS (If my appointed HCS is unwilling, unable, or not reasonably available)

Name:_____

Address:_____

Phone:_____ Alternate phone:_____

Email:_____

HEALTHCARE SURROGATE AUTHORITY (HCS)

My HCS's authority becomes effective when my healthcare provider determines that I am unable to make my own healthcare decisions, unless I initial either or both of the following statements.

If I initial here _____ my HCS's authority to receive my health information takes effect immediately. (upon signing this document)

If I initial here _____ my HCS's authority to make healthcare decisions for me takes effect immediately. (upon signing this document)

While I am able to make my own decisions, my choices will determine the kind of medical treatment I will receive. My healthcare providers will clearly communicate with me about my treatment and any changes even if I allow my HCS to make decisions immediately.

MAKE IT LEGAL

I fully understand the meaning of this Appointment of Healthcare Surrogate. I am emotionally and mentally capable of signing this document.

_____ _____ _____
Signature Printed name Date

Witness 1: _____ _____
Print name Signature

Address: _____

Witness 2: _____ _____
Print name Signature

Address: _____

**** Your healthcare surrogate(s) cannot serve as a witness to this living will.***
At least one witness must be someone other than your spouse or a blood relative.

Next Steps

- ☐ Complete and discuss your living will with your healthcare provider(s).
- ☐ Communicate your choices to your HCS and alternate surrogate.
- ☐ Once your living will has been signed and witnessed, give copies to: your doctor(s), your HCS and alternate surrogate and your loved ones.
- ☐ Keep your original copy where it can be easily found.

Copies of this document have been given to:_____

_____

_____

*The state of Florida does **NOT** require notarization of healthcare surrogate, however some states do. Please check your state's requirements. This space is being provided for those individuals who need notarization.*

Signature: _____County of: _____

The foregoing instrument was acknowledged before me on _____ (date).

By: _____Signature of Notary: _____

Seal of Notary:

5771 Roosevelt Blvd | Clearwater, FL 33760
(727) 467-7423 | **EmpathChoicesforCare.org**