COMBINATION LIVING WILL
AND
DESIGNATION OF HEALTH CARE SURROGATE
(AND HIPAA RELEASE AUTHORIZATION)

I, _____ (PRINCIPAL) of _____County, Florida, willfully and voluntarily make this Living Will and Designation of Health Care Surrogate, and I do hereby declare:

Statement Regarding Life Sustaining Procedures

I desire to make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am both mentally and physically incapacitated and

_☐_ I have a terminal condition,

or _☐_ I have 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 reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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. It is my intention that this declaration be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences of such refusal. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Designation of Health Care Surrogate

In the event that I, _____, (PRINCIPAL) 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: _____

The determination of whether I have become incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures shall be certified in writing by my physician.

Alternate Surrogate

If is unwilling or unable to perform his or her duties, I wish to designate the following persons as my surrogates to make health care decisions for me as authorized by this document, and they shall serve in the following order:

A. First Alternate Surrogate

Name: _____
Address: _____
Phone: _____

B. Second Alternate Surrogate

Name: _____
Address: _____
Phone: _____

C. Third Alternate Surrogate

Name: _____
Address: _____
Phone: _____

Additional Instructions

My surrogate shall have full power and authority to make all health care decisions for me during my incapacity as if I were able to make such decisions myself. In particular, and without limiting my surrogate's authority, my surrogate shall have the following powers:

1. The power to consult expeditiously with appropriate health care providers to provide informed consent, including written consent on an appropriate form, to any medical procedure;

2. The power to make health care decisions for me which my surrogate believes I would have made under the circumstances if I were capable of making such decisions;

3. The power to apply for public benefits, such as Medicare and Medicaid, for me, and to have access to information regarding my income, assets, banking records, and financial records as required to make such application;

4. The power to authorize the release of information and clinical records to appropriate persons to ensure the continuity of my health care; and

5. The power to authorize the transfer and admission of me to or from a health care facility.

Definitions

The following definitions as set forth in Section 765.101 of the Florida Statutes shall apply:

1. "Advance directive" means a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift made pursuant to part V

of chapter 765 of the Florida Statutes.

2. "Attending physician" means the primary physician who has responsibility for the treatment and care of the patient.

3. "Close personal friend" means any person 18 years of age or older who has exhibited special care and concern for the patient, and who presents an affidavit to the health care facility or to the attending or treating physician stating that he or she is a friend of the patient; is willing and able to become involved in the patient's health care; and has maintained such regular contact with the patient so as to be familiar with the patient's activities, health, and religious or moral beliefs.

4. "End-stage condition" means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

5. "Health care decision" means:

a. Informed consent, refusal of consent, or withdrawal of consent to any and all health care, including life-prolonging procedures and mental health treatment, unless otherwise stated in the advance directives.

b. The decision to apply for private, public, government, or veterans' benefits to defray the cost of health care.

c. The right of access to all records of the principal reasonably necessary for a health care surrogate to make decisions involving health care and to apply for benefits.

d. The decision to make an anatomical gift pursuant to part V of chapter 765 of the Florida Statutes.

6. "Health care facility" means a hospital, nursing home, hospice, home health agency, or health maintenance organization licensed in this state, or any facility subject to part I of chapter 394.

7. "Health care provider" or "provider" means any person licensed, certified, or otherwise authorized by law to administer health care in the ordinary course of business or practice of a profession.

8. "Incapacity" means the patient is physically or mentally unable to communicate a willful and knowing health care decision. For the purposes of making an anatomical gift, the term also includes a patient who is deceased.

9. "Informed consent" means consent voluntarily given by a person after a sufficient explanation and disclosure of the subject matter involved to enable that person to have a general understanding of the treatment or procedure and the medically acceptable alternatives, including the substantial risks and hazards inherent in the proposed treatment or procedures, and to make a knowing health care decision without coercion or undue influence.

10. "Life-prolonging procedure" means any medical procedure, treatment, or

intervention, including artificially provided sustenance and hydration, which sustains, restores, or supplants a spontaneous vital function. The term does not include the administration of medication or performance of medical procedure, when such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.

11. "Living will" means:

a. A witnessed document in writing, voluntarily executed by the principal in accordance with Florida Statute 765.302; or

b. A witnessed oral statement made by the principal expressing the principal's instructions concerning life-prolonging procedures.

12. "Persistent vegetative state" means 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.

13. "Physician" means a person licensed pursuant to chapter 458 or chapter 459 of the Florida Statutes.

14. "Principal" means a competent adult executing an advance directive and on whose behalf health care decisions are to be made.

15. "Surrogate" means any competent adult expressly designated by a principal to make health care decisions on behalf of the principal upon the principal's incapacity.

16. "Terminal condition" means 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.

HIPAA Release Authority

I intend for my surrogate to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 USC 1320d and 45 CFR 160-164. This release authority is effective immediately.

Accordingly, I hereby authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health-care professional, dentist, optometrist, health plan, hospital, hospice, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, pathologist, or other provider of medical or mental health care, as well as any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has paid for or is seeking payment from me for such services, to give, disclose and release to my surrogate who is named herein, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. Additionally, my surrogate shall have the ability to ask questions and discuss my

protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to any protected medical information to my surrogate. Such information may also be released to any person designated as a primary or successor agent or attorney-in-fact in a durable power of attorney which I have executed, whether or not such person is presently serving as such, and to any person presently serving as trustee or named as a successor trustee in any revocable or irrevocable trust created by me as grantor.

In determining whether I am incapacitated, all individually identifiable health information and medical records shall be released to the person who is nominated as my surrogate hereunder, including any written opinion relating to my incapacity that the person nominated as my surrogate may have requested. This release authority applies to any information governed by HIPAA and applies even if that person has not yet begun serving as my surrogate.

This authority given to my surrogate shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to my surrogate may be subject to redisclosure by my surrogate and may no longer be protected by HIPAA. The authority given to my surrogate herein has no expiration date and shall expire only in the event that I revoke this Combination Living Will and Designation of Health Care Surrogate in writing and deliver it to my health-care provider. There are no exceptions to my right to revoke this Combination Living Will and Designation of Health Care Surrogate.

Duration

My designation of a health care surrogate shall exist indefinitely from the date I execute this document unless I establish a shorter time or revoke such designation. If I establish a shorter time and if I am unable to make health care decisions for myself when such time period does expire, the authority I have granted my surrogate shall, nevertheless, continue to exist until the time I become able to make health care decisions for myself. I do not wish to have my designation of a surrogate end on a specified date.

Prior Designations Revoked

I revoke any prior Designation of Health Care Surrogate or similar document.

I fully understand that this designation of a health care surrogate will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

I further affirm that this designation of a health care surrogate is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: _____
Address: _____
_____

This Living Will and Designation of Health Care Surrogate is made on _____, 20__, at _____ County, Florida.

_____
Principal

Signature of First Witness

The Principal signed the foregoing Living Will and Designation of Health Care Surrogate in my presence. I am not a person appointed as surrogate by this document. I am an adult, and I am not the spouse nor a blood relative of _____. (PRINCIPAL)

Signature: _____

Print Name: _____

Date:

Signature of Second Witness

The Principal signed the foregoing Living Will and Designation of Health Care Surrogate in my presence. I am not a person appointed as surrogate by this document. I am an adult, and I am not the spouse nor a blood relative of _____. (PRINCIPAL)

Signature: _____

Print Name: _____

Date:

STATE OF FLORIDA §
§
COUNTYOF _____ §

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

_____
Notary Public, State of Florida
Notary's printed name: _____

COMBINATION LIVING WILL
AND
DESIGNATION OF HEALTH CARE SURROGATE
(AND HIPAA RELEASE AUTHORIZATION)

OF

_____

PRINCIPAL