INSTRUCTIONS
FOR COMPLETING THE
COMBINATION LIVING WILL AND DESIGNATION OF HEALTH CARE SURROGATE FORM

To complete the Combination Living Will and Designation of Health Care Surrogate form:

1. Fill in your full name on the first line. It is best to use your given name; not a nickname. The form will automatically add your name in every location.

2. Fill in the County of your residence on the first line.

3. Fill in the name, address, and telephone number of your first health care surrogate on page one. This is the person who will sign for you if you cannot sign for yourself. It is strongly recommended that you enter this person's telephone number.

4. Fill in the name, address, and telephone number of your second health care surrogate on page two. This is the person who will sign for you if you cannot sign for yourself and your first surrogate is not available. It is strongly recommended that you enter this person's telephone number. It is strongly recommended that you name a second surrogate.

5. Fill in your address on page five.

6. Print the form.

7. Initial each of the three lines on page one. (This activates the living will. Please note – if you are sick with the coronavirus (or anything else) and treatment can help you, you **will** receive treatment. A living will does not keep you from receiving treatment – even ventilators, feeding tubes, etc. – if your condition can be treated.)

8. Initial each of the two lines on page two. (This allows your surrogate to speak with health care providers, access medical records, give consent, and sign for you)

9. Initial the first box on page three if you want your surrogate to be able to speak with your health care providers immediately. If you do not initial this box, health care providers will speak to your surrogate only if you cannot speak for yourself.

10. Initial the second box on page three if you want your surrogate to be able to give consent and sign for you even if you can sign for yourself. A surrogate can **never** override your choices so long as you have mental capacity.

11. Date and Sign the form on page five –

    In the presence of **two witnesses** – neither of whom is your designated surrogate or a family member.

12. Have two witnesses sign the form and print their name and address. Make sure they are not your surrogate or a family member.

13. Don't forget to **make copies** of the signed form. Better yet, scan it and keep a digital copy.

If you do not want a living will (i.e., you want to receive all heroic measures at the end of life), call the office at 727-826-0923. We will email you a form that includes health care surrogate only.

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

I, __________________________, 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 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 primary 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

I, __________________________, designate as my health care surrogate under s. 765.202, Florida Statutes:

Name: ________________________________
Address: ________________________________
____
Phone: ________________________________

If prior agent is not willing, able, or reasonably available to perform his or her duties, I designate as my alternate health care surrogate:

Name: ______________________________
Address: ______________________________
____
Phone: ______________________________

Instructions for Health Care

I authorize my health care surrogate to:

___________ (initial here) Receive any of my 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.

While I have decision-making capacity, my wishes are controlling 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.

THIS HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES.

PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND THIS DESIGNATION BY:

(1) SIGNING A WRITTEN AND DATED INSTRUMENT WHICH EXPRESSES MY INTENT TO AMEND OR REVOKE THIS DESIGNATION;

(2) PHYSICALLY DESTROYING THIS DESIGNATION THROUGH MY OWN ACTION OR BY THAT OF ANOTHER PERSON IN MY PRESENCE AND UNDER MY DIRECTION;

(3) VERBALLY EXPRESSING MY INTENTION TO AMEND OR REVOKE THIS DESIGNATION; OR

(4) SIGNING A NEW DESIGNATION THAT IS MATERIALLY DIFFERENT FROM THIS DESIGNATION.

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 OR BOTH OF THE FOLLOWING BOXES:

☐ IF I INITIAL THIS BOX, MY HEALTH CARE SURROGATE'S AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECT IMMEDIATELY.

☐ IF I INITIAL THIS BOX, MY HEALTH CARE SURROGATE'S AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME TAKES EFFECT IMMEDIATELY. PURSUANT TO SECTION 765.204(3), FLORIDA STATUTES, ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY SHALL SUPERSEDE ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE THAT ARE IN MATERIAL CONFLICT WITH THOSE MADE BY ME.

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 (referred to herein as a "covered entity"), 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/settlor/trustor].

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. I authorize my agent to bring a legal action against a covered entity which refuses to accept and recognize this release authority. No covered entity may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR 164.508(b)(4) applies. Further, in order to fulfill my intent as expressed herein, I authorize my agent to sign any documentation that my agent deems necessary or appropriate in order to secure the disclosure of my individually identifiable health information and other medical records. Any information disclosed to my agent may subsequently be disclosed to another party by my agent. My agent shall not be required to indemnify a covered entity or perform any act in the event information is

subsequently disclosed by my agent. 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.

Prior Designations Revoked

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

Dated: ____________________

____
Print name: _________________________
Address: __________________________
____

SIGNATURES OF WITNESSES:

____
Signature
Printed Name: ____________________________
Address: _________________________________
____

____
Signature
Printed Name: ____________________________
Address: _________________________________
____

Provided as a courtesy by:
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