Designation of Health Care Surrogate

In the event that I have been determined to be incapacitated to provide express and informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate:

Name_____

Address_____

Phone ( )_____

To assume the duties as my health care surrogate, pursuant to Florida Statute 641.411. I fully understand that this designation will permit my health care surrogate to provide, withhold, or withdraw consent on my behalf; apply for public benefits to defray the cost of the health care; and to authorize my transfer to or from a health care facility.

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

Comments_____

Acknowledgements

Signature_____ Print Name_____ Date _____

Witness_____ Print Name_____ Date_____

Witness_____ Print Name_____ Date_____