PROXIMITI HEALTH

America Living Will REGISTRY
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DESIGNATION OF HEALTH CARE SURROGATE

On this ___ day of _____, 20__, I, (*Print Name*)_____

of: (Mailing Address)_____

(City and State)_____ (Zip Code)_____

Phone: (_____)_____ Date of Birth:_____

E-Mail Address: _____

If I am at any time incapable of making health care decisions for myself, and it is determined pursuant to Section 765.204, Florida Statutes, that I lack the capacity to make care decisions for myself or to provide informed consent, I designate the persons named below to serve as my health care surrogate to make all health care decisions for me, subject to the restrictions, if any, set forth herein and the statutory restrictions on a health care surrogate's powers, until such time as I regain the capacity to make such decisions or provide informed consent myself. I designate my health care surrogate as my personal representative under 45 CFR § 164.504(g), a portion of the regulations implementing the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), for all health care-related decisions.

I will furnish an exact copy of this designation to my health care surrogate and my alternate surrogate.

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

Name_____ Phone (____)_____

Address_____ Zip_____

Alternate: Name_____ Phone (____)_____

Address_____ Zip_____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration. I designate my health care surrogate as my personal representative under 45 CFR § 164.504(g), a portion of the regulations implementing the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), for all health care-related decisions.

_____ _____
Declarant's Signature Date

_____ _____
1 Witness Signature # 2 Witness Signature

_____ _____
Address Address

Before me, on this ____ day of _____ 20___ , personally appeared :

Declarant _____ whose I.D. is _____

#1 Witness_____ whose I.D. is _____

#2 Witness_____ whose I.D. is _____

to be the Declarant and Witnesses, respectfully, whose names are signed to the forgoing instrument, and who, in the presence of each other, did freely subscribe their names to the Declaration (Health Care Surrogate Designation) on this date, and that each was over the age of majority and of sound mind.

_____ My Commission Expires: _____
Notary Public

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.