

FLORIDA HEALTH CARE DIRECTIVE

(LIVING WILL / DESIGNATION OF HEALTH CARE SURROGATE)

OF

Jane Doe

[This section will appear if you select living will and vary depending on your choices.]

I. LIVING WILL

Declaration made this _____ day of _____, 20____. I, Jane Doe, hereby revoke all previously executed living wills and/or health care directives and willfully and voluntarily 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 incapacitated and

- (a) I have a terminal condition
- (b) I have an end-stage condition
- (c) 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probability of my recovery from such condition or state, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the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.

If I am pregnant, and that fact is known to my physician, this section will have no force or effect during that pregnancy.

If I have a condition stated above, I want to receive artificially administered nutrition and hydration (i.e., food and fluids).

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.

If it is determined that I am unable to make express and informed decisions about the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate my surrogate named in section II to carry out the provisions of this declaration.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

[This section appears if you choose to appoint someone to make health care decisions for you. You can appoint an alternate agent if your first choice is unavailable.]

II. DESIGNATION OF HEALTH CARE SURROGATE

If it is determined that I, Jane Doe, am unable to provide express and informed consent to medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate ("surrogate") for health care decisions:

Name: John Doe
Relation: Spouse
Address: 100 Main Street
Fort Lauderdale, Florida 98872
Phone: (800) 555-1232
Alt. Phone: (800) 555-1232
Email: jdoe@legalzoomsample.com

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: Ann Doe
Relation: Daughter
Address: 109 Main Street
Davie, Florida 98765
Phone: (800) 222-1234
Alt. Phone: (800) 222-1234
Email: anndoe@legalzoomsample.com

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

I authorize my surrogate to direct the disposition of my remains.

I authorize my surrogate to consent to an autopsy of my remains.

I revoke and make null and void any and all other designations of health care surrogate and durable powers of attorney for health care previously made by me.

[This section varies depending upon your choices regarding organ donation.]

III. ANATOMICAL GIFTS

I do not wish to be an organ donor.

IV. GENERAL PROVISIONS

If any provision of this declaration is held to be invalid, such invalidity will not affect the other provisions of this document, and such other provisions will be given effect without the invalid provision.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any similar state laws, and exclusively for the purpose of making a determination of my incapacitation or inability to direct my own health care decisions and obtaining a physician affidavit of such, I authorize any health care provider to disclose to the person named herein as my health care surrogate, alternate health care surrogate, or second alternate health care surrogate, as applicable, any pertinent individually identifiable health information sufficient to determine whether I am, by reason of illness or mental or physical disability, incapacitated or incapable of directing my own health care decisions. In exercising such authority, my health care surrogate will constitute my "personal representative" as defined by HIPAA.

Upon the determination of my incapacitation or incapability to direct my own health care decisions, I intend for the person named herein as my health care surrogate, alternate health care surrogate, or second alternate health care surrogate, as applicable, to be treated as my "personal representative" under HIPAA and any similar state laws, and as such to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records.

It is my intent that this document be legally binding and effective. If the law does not recognize the legal validity of this document, it is my intention that this document be taken as a formal declaration of my intentions concerning all of the above provisions. Copies of this document have the same effect as the original.

All persons or entities that in good faith endeavor to carry out the provisions of this document will not be liable to me, my estate, or my heirs for any damages or claims arising because of their actions or inactions based on this document. My estate will indemnify and hold them harmless.

IN WITNESS WHEREOF, I have executed this document on the date below:

Signature of Jane Doe

Dated: _____, 20____

100 Main Street
Miami, Florida 91887

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SAMPLE

WITNESS DECLARATIONS

Under penalty of perjury, each of the undersigned declares that: (1) Jane Doe has been personally known to me (or that the individual's identity was proven to me by convincing evidence), and I believe him or her to be of sound mind and not under duress, fraud, or undue influence; (2) Jane Doe signed or acknowledged this document in my presence, and I did not sign Jane Doe's signature; (3) I am not related to Jane Doe by blood, adoption, or marriage; (4) I am not entitled to any part of Jane Doe's estate or directly financially responsible for his or her medical care; (5) I am competent and at least eighteen years of age; (6) I am not Jane Doe's doctor or physician, or an employee of Jane Doe's doctor or physician; and (7) I am not the operator or an employee of a community care facility or a residential care facility for the elderly.

Signature: _____

Print Name: _____

Address: _____

Signature: _____

Print Name: _____

Address: _____

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