**HALIFAX HEALTH**
MEDICAL CENTER OF DAYTONA BEACH: 303 N. CLYDE MORRIS BLVD., DAYTONA BEACH, FL 32114
MEDICAL CENTER OF PORT ORANGE: 1041 DUNLAWTON AVE., PORT ORANGE, FL 32127
TWIN LAKES SURGERY CENTER: 1890 LPGA BLVD., STE. 200, DAYTONA BEACH, FL 32117

Patient Name
Adm. Date Dr.
Date of Birth Age Sex
MR # Visit #

# GUIDELINES FOR DESIGNATING A HEALTH CARE SURROGATE

A competent adult may designate a person to serve as a Health Care Surrogate, to make health care decisions and provide informed consent if he/she is incapable of making health care decisions or providing informed consent.

The designation must be in writing and signed in the presence of two adult witnesses, one of whom must not be the spouse, a blood relative, an heir to the person's estate or responsible for paying the person's health care costs. The person designated as surrogate shall not act as witness to the execution of the document.

The health care facility will ask for the name and address of your designated surrogate at the time of admission. In addition you will be asked to provide a copy of the document which details your wishes in the event you become incapacitated. The surrogate's name will be entered on your medical record.

**Effective Date and Duration:**
The health care surrogate designation becomes effective upon, and only during any period of incapacity to consent.

The incapacity to consent must be determined by your physician.

Unless the document states a time of termination the designation shall remain in effect until removed by you.

**The Surrogate's Powers:**
The surrogate may act on your behalf to make health care decisions during your incapacity. Your designation can be very specific about the surrogate's power, including whether or not the surrogate can withhold or withdraw life support.

In addition your surrogate may have access to your clinical records, and may authorize the release of records to appropriate people. The surrogate may apply for public benefits and authorize your transfer to or from a health care facility.

**Restrictions on Surrogate's Powers:**
Unless expressly delegated, health care surrogate may not provide consent for:
- Abortion
- Sterilization
- Electroshock therapy
- Psychosurgery
- Experimental treatments or therapies except as recommended by federally approved institutional review boards
- Voluntary admission to a mental health facility
- Withholding or withdrawing life support from a pregnant patient prior to viability as defined in Statute 390.001.

**Revocation:**
Your designation may be revoked at any time:
- by means of a physical cancellation or by destruction of the designation document
- by means of an oral expression of intent to revoke
- by means of a subsequently executed advance directive that is materially different

Unless otherwise provided in the advance directive or in an order of dissolution or annulment of marriage, the dissolution or annulment of your marriage revokes the designation of your former spouse as a surrogate.

**Alternatives:**
You may designate one or more alternates to assume the responsibility if your surrogate becomes unavailable or refuses to act.

**Protection of third parties who rely on your Surrogate:**
No health care facility, physician or other professional or hospital employee shall be liable to you, your estate, your heirs, or assignees for the decisions of your health care surrogate.

*This document is supplied for you* as a *courtesy by Halifax Health. You may substitute it with any document that meets the intent of the law for health care surrogate and is properly executed. You may want to discuss this with legal counsel although it is not required by law. Please inform your family that you have executed this document or any similar document. You may want to give* a *copy to your physician and also to your family.*

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# DESIGNATION OF HEALTH CARE SURROGATE

CONTINUED FROM PAGE 1

Name: _____
(Last) (First) (Middle Initial)

In the event that I 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: _____

City/State/Zip: _____

Phone: (home)_____ (work) _____

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

Name: _____

Address: _____

City/State/Zip: _____

Phone: (home)_____ (work) _____

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, 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 admissions to or transfer from a health care facility.

ADDITIONAL INSTRUCTIONS (optional):

_____

_____

_____

I further affirm that this designation 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:

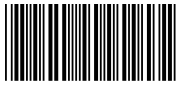
Name: _____

Name: _____

Name: _____

Signed: _____Date: _____

Witness: 1. _____ 2. _____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