How to Complete Your Health Care Surrogate Form

Here's a brief rundown on each section of this form.

1. **Health Care Surrogate Name and Details**
   This is where you name your health care surrogate and a backup.

2. **Health Care Surrogate Powers**
   This is the list of powers you're giving to your health care surrogate. You're allowing this person to:

   - Receive your health information
   - Make healthcare decisions for you
   - Decide to make an anatomical gift

   You may want to give your health care surrogate a copy of your living will and other advance directives. This will help your surrogate perform these tasks based on your wishes.

3. **Other Instructions and Limits**
   This section is optional. You can list more instructions or limits for your health care surrogate.

4. **The Responsibility to Keep Me Informed**
   There's nothing to fill out in this section. You just need to read it through. It calls out that your doctors and health care surrogate need to keep you reasonably informed.

5. **Changing or Canceling This Form**
   Again, there's nothing to fill out in this section. You just need to read it through. It tells you how you can change or cancel this form.

6. **When My Health Care Surrogate's Powers Take Effect**
   This section tells you when your health care surrogate can start acting for you, which is typically when your doctor says you're no longer able to make decisions on your own. But you can have it happen earlier by initialing the boxes in this section.

7. **Signatures**
   You and your witnesses need to sign and date the form. At least one witness has to be someone other than a spouse or blood relative. Your health care surrogate can't serve as a witness.

Health Care Surrogate Form

1 Health Care Surrogate Name and Details

Print your full name in the empty space of the first sentence below. Then enter the name, address, and phone number of your health care surrogate and backup.

I, ____, appoint as my health care surrogate under section 765.202, Florida Statutes:

NAME: ______________________________

ADDRESS: ______________________________

PHONE: ______________________________

If my health care surrogate is not willing, able, or reasonably available to perform his or her duties, I appoint as my backup health care surrogate:

NAME: ______________________________

ADDRESS: ______________________________

PHONE: ______________________________

2 Health Care Surrogate Powers

Enter your initials where asked below.

I give my health care surrogate permission to:

__________ *initial here*

Receive any and all of my health information.

That means my health care surrogate can receive health information that is:

- Spoken, written, or recorded in any form or medium
- Created or received by anyone involved in my healthcare, such as a healthcare provider, healthcare facility, health plan, employer, life insurer, school, university, or healthcare clearinghouse
- Related to my past, present, or future physical or mental health condition
- Related to healthcare provided to me
- Related to the past, present, or future payment for healthcare provided to me

Source: State of Florida's Designation of Health Care Surrogate form.

Devoted Health is an HMO and PPO plan with a Medicare contract. Our D-SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. Y0142_22M257_C

____
initial here

Make all healthcare decisions for me.

My health care surrogate will do their best to follow my wishes, like those that may be stated in my living will. My health care surrogate can:

- Give informed consent, refuse consent, or withdraw consent to any and all of my healthcare, including life-prolonging procedures
- Apply for private, public, government, or veteran's benefits for me to help pay the cost of my healthcare
- Access my health information to make decisions about my healthcare

____
initial here

Decide to make an anatomical gift as detailed in part V of chapter 765, Florida Statutes.

3 Other Instructions and Limits (optional)

If you'd like to give more instructions — or limits — for your health care surrogate, state those details here.

____

____

____

4 My Right to Stay Informed

While I am still able to make decisions for myself, my wishes are in control — they override the wishes of my healthcare surrogate. My doctor and healthcare providers must clearly communicate to me the treatment plan — or any changes to the treatment plan — before they act on it.

To the extent that I am able to understand, my health care surrogate will keep me reasonably informed of matters that concern me and of all decisions he or she makes for me.

If I become incapacitated, this health care surrogate form is not affected, except as detailed in Chapter 765, Florida Statutes.

5 Changing or Canceling This Form

As detailed in section 765.104, Florida Statutes, I understand that as long as I can make my own decisions, I can change or cancel this form at any time by doing one of the following:

- Signing a written and dated document that expresses my intent to change or cancel this form.
- Physically destroying this form. I can do that on my own or have someone else do it for me, as long as I'm telling them to and they do it in front of me.
- Speaking my desire to change or cancel this form.
- Signing a new health care surrogate form that has meaningful differences from this one.

I also understand that if I change or cancel this form, it's important to let my doctor and Devoted Health know about it.

6 When My Health Care Surrogate's Powers Take Effect

Initial the boxes below only if you want your health care surrogate's power to take effect right away.

My health care surrogate's power will take effect when my primary doctor determines that I am unable to make my own health care decisions. If I want it to take effect sooner, I'll initial one or both of the boxes below:

____
initial here

If I initial here, my health care surrogate's power to receive my health information takes effect right away.

____
initial here

If I initial here, my health care surrogate's power to make healthcare decisions for me takes effect right away.

7 Signatures

Complete and sign this form in front of 2 witnesses. Then, ask the witnesses to sign below. At least one witness has to be someone other than a spouse or blood relative. Your health care surrogate can't serve as a witness.

SIGNATURE: ________________ DATE: ________________

PRINTED NAME: ________________

ADDRESS: ________________

Witness One

SIGNATURE: ________________ DATE: ________________

PRINTED NAME: ________________

ADDRESS: ________________

Witness Two

SIGNATURE: ________________ DATE: ________________

PRINTED NAME: ________________

ADDRESS: ________________