

# DESIGNATION OF HEALTH CARE SURROGATE

Name \_\_\_\_\_

In the event 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 \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

I fully understand that this document will permit my surrogate to make health care decisions, except for anatomical gifts when I have executed an anatomical gift declaration pursuant to law, and to provide, withhold and withdraw consent on my behalf; to apply public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

I authorize my surrogate to request, receive, obtain and review, and be granted full and unlimited access to, and consent to the disclosure of complete unredacted copies of any and all health, medical and financial information and any information or records referred to in 45 C.F.R. Sec. 164.501 and regulated by the Standards for Privacy of Individually Identifiable health Information found in 65 Fed. Reg. 82462 as protected private records or otherwise covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that the information contained in my health and medical records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), AIDS-related complex (ARC) and human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol or drug abuse or addiction. I understand that I may have access to or receive an accounting of the information to be used or disclosed as provided in 45 C.F.R. Sec. 164.524 et seq. I further understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that any disclosure of this information carries with it the potential for an unauthorized further disclosure of this information by third parties and that such further disclosure may not be protected under HIPAA. In order to induce the disclosing party to disclose the aforesaid private and/or protected confidential information, I forever release and hold harmless said disclosing party who relies upon this instrument from any liability under confidentiality rules arising under HIPAA as a consequence of said disclosure. I authorize my surrogate to execute on my behalf any releases or other documents that may be required in order to obtain this information.

Additional Instructions (optional):

NOTE: **In the space provided below, insert any specific desires, special provisions or limitations which you desire.**

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 \_\_\_\_\_

(Signed): \_\_\_\_\_

Witness \_\_\_\_\_ Witness \_\_\_\_\_

Street Address \_\_\_\_\_ Street Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_ City, State & Zip \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

*At least one witness must not be a husband or wife or a blood relative of the principal.*