# An Advanced Directive for Florida
## A Practical Form for All Adults

A **Florida advance directive** is a set of declarations given to medical professionals on behalf of a patient who may be unable to make decisions about their treatment during the time of care. The State of Florida recognizes a Living Will Declaration, outlining a patient's wishes, and a Designation of Health Care Surrogate, which appoints a third party to make health care decisions on behalf of the patient.

This form allows you to express your wishes for future health care and to guide decisions about that care. It does not address financial decisions. Although there is no legal requirement for you to have an advance directive, completing this form may help you to receive the health care you desire.
If you are 18 years old or older and are able to make and communicate health care decisions, you may use this form.

This form complies with Florida State Statutes (in FS § 765.201-765.309).

Definitions:

Advanced Directive (§ 765.101(1) – "Advanced directive" means a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principals' health care or health information, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift made pursuant to part V of this chapter.
Health care (§ 765.101(5)) - "Health care" means care, services, or supplies related to the health of an individual and includes, but is not limited to, preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the individual's physical or mental condition or functional status or that affect the structure or function of the individual's body.
Health care decision (§ 765.101(6)) - "Health care decision" means:

(a) Informed consent, refusal of consent, or withdrawal of consent to any and all health care, including life-prolonging procedures and mental health treatment, unless otherwise stated in the advance directives.

(b) The decision to apply for private, public, government, or veterans' benefits to defray the cost of health care.
(c) The right of access to health information of the principal reasonably necessary for a health care surrogate or proxy to make decisions involving health care and to apply for benefits.
(d) The decision to make an anatomical gift pursuant to part V of this chapter.
Living Will (§ 765.101(13)) – "Living will" or "declaration" means:
(a) A witnessed document in writing, voluntarily executed by the principal in accordance with s. 765.302; or
(b) A witnessed oral statement made by the principal expressing the principal's instructions concerning life-prolonging procedures.
Minor's principal (§ 765.101(14)) - "Minor's principal" means a principal who is a natural guardian as defined in s. 744.301(1); legal custodian; or, subject to chapter 744, legal guardian of the person of a minor.
Surrogate (§ 765.101(21)) - "Surrogate" means any competent adult expressly designated by a principal to make health care decisions and to receive health information. The principal may stipulate whether the authority of the surrogate to make health care decisions or to receive health information is exercisable immediately without the necessity for a determination of incapacity or only upon the principal's incapacity as provided in s. 765.204.

DESIGNATION OF HEALTH CARE SURROGATE

I, _____, designate as my health care surrogate under s. 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 designate as my alternate health care surrogate:

Name: _____

Address: _____

_____

Phone: _____

## INSTRUCTIONS FOR HEALTH CARE

I authorize my health care surrogate to:

_____(initial) Receive any of my health information, whether oral or recorded in any form or medium, that:

1. Is created or received by a health care provider, health care facility, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

2. Relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

I further authorize my health care surrogate to:

_____(initial) Make all health care decisions for me, which means he or she has the authority to:

1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.



2. Apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.

3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.

4. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.

_____(initial)Specific instructions and restrictions: _____

_____
_____

_____
_____

_____
_____

While I have decision making capacity, my wishes are controlling, and my physicians and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.

To the extent I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

THIS HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES.

PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND THIS DESIGNATION BY:

(1) SIGNING A WRITTEN AND DATED INSTRUMENT WHICH EXPRESSES MY INTENT TO AMEND OR REVOKE THIS DESIGNATION;

(2) PHYSICALLY DESTROYING THIS DESIGNATION THROUGH MY OWN ACTION OR BY THAT OF ANOTHER PERSON IN MY PRESENCE AND UNDER MY DIRECTION;

(3) VERBALLY EXPRESSING MY INTENTION TO AMEND OR REVOKE THIS DESIGNATION; OR

(4) SIGNING A NEW DESIGNATION THAT IS MATERIALLY DIFFERENT FROM THIS DESIGNATION.



MY HEALTH CARE SURROGATE'S AUTHORITY BECOMES EFFECTIVE WHEN MY PRIMARY PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN HEALTH CARE DECISIONS UNLESS I INITIAL EITHER OR BOTH OF THE FOLLOWING BOXES:

IF I INITIAL THIS BOX [____], MY HEALTH CARE SURROGATE'S AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECT IMMEDIATELY.

IF I INITIAL THIS BOX [____], MY HEALTH CARE SURROGATE'S AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME TAKES EFFECT IMMEDIATELY. PURSUANT TO SECTION 765.204(3), FLORIDA STATUTES, ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY SHALL SUPERSEDE ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE THAT ARE IN MATERIAL CONFLICT WITH THOSE MADE BY ME.

SIGNATURES: Sign and date the form here:

_____(date) _____(sign your name)

_____(print your name)

_____(address)

_____(city) _____ (state)

SIGNATURES OF WITNESSES: *(At least one witness must not be a spouse or a blood relative of the principal)*

First Witness

_____ (print name)

_____(address)

_____(city)

_____(state)

_____(signature of witness)

_____(date)

Second Witness

_____ (print name)

_____(address)

_____(city)

_____(state)

_____(signature of witness)

_____(date)

DESIGNATION OF HEALTH CARE SURROGATE

FOR MINOR

I/We, _____(name/names), the [ ] natural guardian(s) as defined in s. 744.301(1), Florida Statutes; [ ] legal custodian(s); [ ] legal guardian(s) [check one] of the following minor(s):

_____;

_____;

_____,

pursuant to s. 765.2035, Florida Statutes, designate the following person to act as my/our surrogate for health care decisions for such minor(s) in the event that I/we am/are not able or reasonably available to provide consent for medical treatment and surgical and diagnostic procedures:

Name: _____

Address: _____

Zip Code: _____

Phone: _____

If my/our designated health care surrogate for a minor is not willing, able, or reasonably available to perform his or her duties, I/we designate the following person as my/our alternate health care surrogate for a minor:

Name: _____

Address: _____

Zip Code: _____

Phone: _____

I/We authorize and request all physicians, hospitals, or other providers of medical services to follow the instructions of my/our surrogate or alternate surrogate, as the case may be, at any time and under any circumstances whatsoever, with regard to medical treatment and surgical and diagnostic procedures for a minor, provided the medical care and treatment of any minor is on the advice of a licensed physician.

I/We fully understand that this designation will permit my/our designee to make health care decisions for a minor and to provide, withhold, or withdraw consent on my/our behalf, to apply for public benefits to defray the cost of health care, and to authorize the admission or transfer of a minor to or from a health care facility.

I/We will notify and send a copy of this document to the following person(s) other than my/our surrogate, so that they may know the identity of my/our surrogate:

Name: _____

Name (s): _____/_____

Signed: _____/_____

Date: _____

WITNESSES:

1. _____
2. _____

# LIVING WILL

Declaration made this _____day of _____, _____(year), I, _____, 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

_____ (initial) I have a terminal condition

Or _____ (initial) I have an end-stage condition

Or _____ (initial) I am in a persistent vegetative state

and if my primary physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, 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.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

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

Additional Instructions (optional):

_____
_____
_____
_____

_____ (Signed)
_____ (Print Name)

First Witness *(At least one witness must not be a spouse or a blood relative of the principal)*

_____ (Signed)
_____ (Print Name)

_____ (Address)

_____ (Phone)

Second Witness

_____ (Signed)
_____ (Print Name)

_____ (Address)

_____ (Phone)