**Medical Durable Power of Attorney**

I, _____, DOB: _____ whose address is _____ _____, the principal, an adult of sound mind, execute this Medical Durable Power of Attorney (subsequently called "power") freely and voluntarily, with an understanding of its purposes and consequences. I intend my statements in this instrument to constitute clear and convincing evidence of my wishes concerning medical treatment.

**Designation of Healthcare Surrogate**
I designate the individual named below, to serve as my Healthcare Surrogates giving to my Healthcare Surrogate the power to make decisions with regard to my health care if and when I am unable to make my own health care decisions.

Name: _____
Address: _____
Phone: _____

**Duration**
This Medical Durable Power of Attorney is not limited to a term of years; it shall terminate only upon its revocation as provided in this instrument, or upon my death, whichever event first occurs. The authority of my Healthcare Surrogate does not terminate if I become disabled or incapacitated.

**General Grant**
My Healthcare Surrogate has authority to do all acts related to my personal care, residential placement, and medical treatment that my Healthcare Surrogate determines to be appropriate, including but not limited to the items specifically mentioned in this instrument. If my Healthcare Surrogate is not available, I intend the following statements to guide decisions about my care and treatment.

**Effect on Legal Capacity**
A formal adjudication of my incapacity is not required for my Healthcare Surrogate to exercise the authority granted by me under this instrument.

**Instructions Concerning Medical Evaluations and Treatment**
In exercising the authority granted to my Healthcare Surrogate, my Healthcare Surrogate is instructed to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner however rudimentary, even by blinking my eyes. My Healthcare Surrogate is further instructed that if I am unable to give an informed consent to medical treatment, my Healthcare Surrogate shall give or withhold consent

based upon any treatment choices I have expressed while competent, whether under this instrument or otherwise. If my Healthcare Surrogate cannot determine the treatment choice I would want made under the circumstances, then I request that my Healthcare Surrogate make the choice for me based upon what my Healthcare Surrogate believes to be in my best interests. I request that my Healthcare Surrogate's decision be guided by taking into account the provisions of this instrument; any preferences that I may previously have expressed on the subject; what my Healthcare Surrogate believes I would want done in the circumstances if I were able to express myself; and any information given to my Healthcare Surrogate by the physicians treating me as to my medical diagnosis and prognosis and the intrusiveness, pain, risks, and side effects of the treatment.

I want to leave my family, friends and persons who care about me with assurances of my love, and without the burdens of guilt or conflict. My purposes in leaving these instructions are to alleviate uncertainty that otherwise may arise in connection with decisions about my medical care, to promote family harmony and to clarify instructions to my health care providers. My Healthcare Surrogate's authority to act on my behalf concerning my medical care includes, but is not limited to, decisions concerning artificial life support, medical treatment, surgery and other medical procedures; artificial nourishment and hydration; resuscitation decisions (including Do Not Resuscitate [DNR] orders and CPR directives); amputation of my limbs; blood transfusions; experimental drugs and medical procedures; the administration of pharmaceutical agents; and arrangements for my long term care.

I affirm my belief in the importance and value of my personal dignity, both in living and in dying.

**Long Term or Hospice Care**

My Healthcare Surrogate is authorized to select a facility for my nursing, convalescent or hospice care and to establish my residence and placement in a secure unit therein if, in my Healthcare Surrogate's sole and exclusive discretion, the facility provides the quality of care appropriate for my medical needs and mental condition. For the purposes of arranging or providing long term care, my Healthcare Surrogate has authority to facilitate my transportation and establish my legal residence within or beyond the state of Florida.

**Maintain Me in my Residence**

My Healthcare Surrogate is also authorized to take whatever steps are necessary or advisable to enable me to remain in my personal residence as long as it is reasonable under the circumstances. I realize that my health may deteriorate so that it becomes necessary to have round-the-clock nursing care if I am to remain in my personal residence, and I direct my Healthcare Surrogate to obtain

that care, including any equipment that might assist in my care, as is reasonable under the circumstances. Specifically, I do not want to be hospitalized or put in a convalescent or similar home as long as my Healthcare Surrogate determines that it is reasonable to maintain me in my personal residence.

**Medical Information and Medical Records**
Acting on my behalf, my Healthcare Surrogate may have access to all of my medical information and photocopies of my medical records from my health care providers including, but not limited to, physicians, dentists, podiatrists, physical therapists, chiropractic physicians and chiropractors, pharmacists, optometrists, psychologists, social workers, hospitals, hospices and other treatment facilities; may disclose medical and related information concerning my treatment to appropriate health care providers; may admit or transfer me to such hospitals, hospices, or treatment facilities as my Healthcare Surrogate determines to be in my best interests. In order for my Healthcare Surrogate to fulfill his or her duties, my treating physician or hospital is to discuss with my Healthcare Surrogate my medical condition and to disclose all medical records.

**Employ and Discharge Health Care Personnel**
My Healthcare Surrogate may employ and discharge medical personnel including physicians, psychiatrists, dentists, nurses, and therapists as my Healthcare Surrogate determines necessary for my physical, mental and emotional well-being, and to pay them or any of them, reasonable compensation.

**Pain Relief**
I authorize my Healthcare Surrogate to consent on my behalf to the administration of whatever pain-relieving drugs and surgical pain relieving procedures my Healthcare Surrogate, upon medical advice, believes may provide comfort to me, even though such drugs or procedures may lead to pharmaceutical addictions, lower blood pressure, lower levels of breathing, or may hasten my death. Even if artificial life support or aggressive medical treatment has been withdrawn or refused, I want to be kept as comfortable as possible.

**Consent to Psychiatric Treatment**
My Healthcare Surrogate may arrange (upon the execution of a certificate by two independent psychiatrists who have examined me and in whose opinions I am in immediate need of hospitalization because of mental disorders, alcoholism or drug abuse) for my voluntary admission to an appropriate hospital or institution for treatment of the diagnosed problem or disorder; to arrange for private psychiatric and psychological treatment for me; and to revoke, modify, withdraw or change consent to the hospitalization, institutionalization or private treatment which I or my Healthcare Surrogate may have previously given. The consent of my Healthcare Surrogate to my hospitalization for psychiatric help, alcoholism

or drug abuse has the same legal effect, subject to applicable local law, as a voluntary admission made by me.

**Grant Releases**
My Healthcare Surrogate may grant, in conjunction with any instructions given under this instrument, releases to hospital staff, physicians, nurses and other medical and hospital administrative personnel who act in reliance on instructions given by my Healthcare Surrogate or who render written opinions to my Healthcare Surrogate in connection with any matter described in this instrument from all liability for damages suffered or to be suffered by me; and to sign documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice" as well as any necessary waivers of or releases from liability required by any hospital or physician to implement my wishes regarding medical treatment or non-treatment.

**Living Will**
I have executed a living will declaration under the laws of the state of Florida. To the extent that any provisions of this medical durable power of attorney are deemed to conflict with my living will, living will shall prevail. If I become unconscious or incompetent in a state where my living will declaration or this medical durable power of attorney is not honored, I authorize my Healthcare Surrogate to transport me or arrange for my transportation to a jurisdiction where my medical directives will be enforceable.

**Anatomical Gifts**
I authorize my Healthcare Surrogate to decide whether or not to make anatomical gifts on my behalf for the limited purpose of transplantation, which shall take effect upon my death, to such persons and organizations as my Healthcare Surrogate shall deem appropriate, and to execute such papers and do such acts as shall be necessary, appropriate, incidental, or convenient in connection with such gifts.

**Health Insurance Portability and Accountability Act**
In addition to the other powers granted by this document, I grant to my Healthcare Surrogate the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996 and its regulations ("HIPAA") immediately upon my signing this document.

Pursuant to HIPAA, I specifically authorize my Healthcare Surrogate as my HIPAA personal representative to request, receive and review any information regarding my physical or mental health, including, without limitation all HIPAA protected health information, medical and hospital records; to execute on my behalf any authorizations, releases or other documents that may be required in

order to obtain this information; and to consent to the disclosure of this information. I further authorize my Healthcare Surrogate to execute on my behalf any documents necessary or desirable to implement the health care decisions that my Healthcare Surrogate is authorized to make under this document.

By signing this Medical Durable Power of Attorney, I specifically empower and authorize my physician, hospital or health care provider to release any and all medical records to my Healthcare Surrogate or my Healthcare Surrogate's designee. Further, I waive any liability to any physician, hospital or any health care provider who releases any and all of my medical records to my Healthcare Surrogate and acknowledge that the health information that would otherwise be protected under HIPPA will no longer be protected or private.

**Guardian**
The authority conferred upon my Healthcare Surrogate obviates the need for appointment of a guardian. But should any proceeding commence for appointment of a guardian, I nominate my Healthcare Surrogate to serve as guardian, without bond.

**Third-Party Reliance**
Third parties may accept as binding the instructions and decisions of my Healthcare Surrogate regarding my medical treatment. No person or medical facility or institution may incur any liability to me or to my estate by complying with my Healthcare Surrogate's instructions. My Healthcare Surrogate is authorized to execute consents, waivers, and releases of liability on my behalf and on behalf of my estate to all medical personnel who comply with my Healthcare Surrogate's instructions. Furthermore, I authorize my Healthcare Surrogate to indemnify and hold harmless, at my expense, any third party who accepts and acts under this power of attorney, and I agree to be bound by any indemnity entered into by my Healthcare Surrogate.

**Enforcement by Healthcare Surrogate**
I authorize my Healthcare Surrogate to seek on my behalf and at my expense:

A declaratory judgment from any court of competent jurisdiction interpreting the validity of this instrument or any of the acts authorized by this instrument, but a declaratory judgment is not necessary in order for my Healthcare Surrogate to perform any act authorized by this instrument; or an injunction requiring compliance with my Healthcare Surrogate's instructions by any person providing medical or personal care to me; or actual and punitive damages against any person responsible for providing medical or personal care to me who willfully fails or refuses to follow my Healthcare Surrogate's instructions.

**Release of Healthcare Surrogate's Personal Liability**
My Healthcare Surrogate shall not incur any personal liability to me or my estate arising from the good faith exercise of discretion or performance of acts and duties relating to my medical treatment and personal care.

**Reimbursement of Healthcare Surrogate**
My Healthcare Surrogate is entitled to reimbursement for all reasonable expenses arising from the performance of acts and duties relating to my medical treatment and personal care under this instrument.

**Copies Effective as Originals**
Photocopies of this instrument may be effective and enforceable as originals, and third parties are entitled to rely on photocopies of this instrument for the full force and effect of all stated terms.

**Interstate Enforceability**
It is my intention that the terms of this instrument be honored in any jurisdiction, regardless of its conformity to that jurisdiction's technical requirements and legal formalities.

**Amendment and Revocation**
I reserve the right to revoke my Healthcare Surrogate's authority orally or in writing.

**Revocation of Prior Powers**
Unless otherwise expressly provided herein, this medical durable power of attorney expressly supersedes all prior medical durable powers of attorney that I previously may have executed. Execution of this instrument does not, however, affect any other unrelated powers previously conveyed by me through general or limited powers of attorney, or my living will, which powers and living will are to continue in full force and effect until revoked by me or otherwise terminated.

Dated: _____.

_____

STATE OF FLORIDA )
COUNTY OF _____ )

The foregoing instrument was acknowledged by _____ by means of ☐ physical presence or ☐ online notarization and who is ☐ personally known to me or who ☐ produced _____ as identification.

[Seal]

_____
(Signature of Notarial Officer)
Notary Public for the State of Florida
My commission expires: _____

_____
[Signature of Witness #1]

_____
[Printed or typed name of Witness #1]

_____
[Address of Witness #1, Line 1]

_____
[Address of Witness #1, Line 2]

_____
[Signature of Witness #2]

_____
[Printed or typed name of Witness #2]

_____
[Address of Witness #2, Line 1]

_____
[Address of Witness #2, Line 2]