DESIGNATION OF HEALTH CARE SURROGATE

Declaration make this ____ day of _____, 2_____.

I, _____

Of (mailing address) _____

(city/state) _____ (zip) _____

(Social Security number) _____ (phone number) _____

willfully and voluntarily, in the even that my physician determines that I am incapacitated or incompetent to provide express and informed consent for medical treatment, surgical or diagnostic procedures, wish to designate the following person to make those decisions for me.

Name of Designee: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

In the event that my first choice is unable to serve, I appoint:

Name of Designee: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

A. When effective:
My health care surrogate named herein shall have the authority and poser to act on my behalf during such time as I shall not have the capacity to make health care decisions for myself, as determined by my attending physician and a second physician.

B. Revocation of prior designation:
Any designation of a health care surrogate made prior to the date hereof is hereby revoked.

C. Powers:

1. Consult with my health care providers to provide informed consent for me.
2. Give any consent in writing with respect to my healthcare, or refuse consent or withdraw consent to my health care.
3. Have access to any and all of medical records and have authority to authorize release of such information to appropriate persons.
4. Authorize the transfer and admission of me to or from a health care facility.
5. Apply at his/her discretion for public benefits, such as Medicare and Medicaid, but not limited to this, and in this regard and for this purpose, to have access to information regarding my income and assets.
6. **Restrictions:** My health care surrogate may not provide consent for:
   - ***** abortion
   - ***** sterilization
   - ***** psychosurgery
   - * electroshock therapy
   - * voluntary admission to a mental health facility
   - * withholding or withdrawing life-prolonging procedures
7. **Withholding or withdrawing Life-Prolonging Procedures:** If I have executed a Living Will requesting life-prolonging procedures to be withheld or withdrawn, my health care surrogate designated herein is hereby authorized to consent to the withholding or withdrawing of life-prolonging procedures.
8. **Reliance:** My health care surrogate and all health care facilities and health care providers shall be entitled to rely upon the designation until such person or facility receives actual knowledge or actual notice of the revocation of this Designation.

9. **Indemnity:** My estate shall hold harmless and indemnity my health care surrogate from all liability for acts done in hood faith on my behalf pursuant to this Designation.

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

_____ _____
(signed) (date)

This Declaration is known to me, and I believe him/her to be of sound mind.

_____ _____
(Witness) (Witness)

_____ _____
(Address) (Address)

_____ _____
(City/State) (City/State)

_____ _____
(Phone) (Phone)

I have been appointed and accept such appointments as the above individual's Health Care Surrogate.

_____ _____
(Health Care Surrogate's signature #1) (date)

_____ _____
(Health Care Surrogate's signature #2) (date)

This Declaration does not have to be notarized, but may be if desired:

Before me, the undersigned authority, on this ____ date of _____, 2____, personally

Appeared (Declarant) _____ Whose I.D. is: _____

#1 Witness (print name) _____ Whose I.D. is: _____

and #2 Witness (print name) _____ Whose I.D. is: _____

or know to me to be the Declarant and the witnesses, respectively, whose names were signed to the foregoing instrument, and who in the presence of each other, did freely subscribe their names to the attached Declaration (Designation of a Health Care Surrogate) on this date, and that said Declarant at the time of execution of said Declaration was over the age of majority and of sound mind.

_____ _____
(Notary Public) (date)

My Commission Expires: _____