

Designation of Health Care Surrogate

Name:

PRINT: (Last) (First) (Middle Initial)

In the event that 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: _____

Address: _____

Phone: _____

If my surrogate is unwilling or unable to perform his/her duties, I wish to designate as my alternate surrogate:

Name: _____

Address: _____

Phone: _____

I fully understand that this designation will permit my designee to:

1. make health care decisions for me, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law;
2. provide, withhold, or withdraw consent on my behalf;
3. apply for public benefits to defray the cost of health care; and
4. authorize my admission to or transfer from a health care facility.

