A. Appointment of Health Care Surrogate:

I, _____ , hereby appoint the following person as my **health care surrogate:**
(print your name)

Name of Appointed Health Care Surrogate: _____

Address: _____

Phone Number: _____ Alternate Phone Number: _____

If my health care surrogate is not willing, able, or available to perform his or her duties, I appoint the following person as my **alternate health care surrogate:**

Name of Alternate Health Care Surrogate: _____

Address: _____

Phone Number: _____ Alternate Phone Number: _____

B. 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 check and initial one or both of the following boxes:

❒ _____ *(initial)* I want my health care surrogate to have immediate access to my health information.

❒ _____ *(initial)* I want my health care surrogate to immediately begin making my health care decisions. To the extent I can understand, my health care surrogate and health care provider shall keep me informed of all decisions made on my behalf and matters concerning me. (As long as I am able to make health care decisions, my preferences for care will be followed.)

C. Authority of My Health Care Surrogate – (Please check and initial the box next to each applicable statement below):

❒ _____ *(initial)* **I authorize my health care surrogate to receive any of my health information** 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 physical or mental health or condition, the provision of health care to me, or the payment for my health care.

❒ _____ *(initial)* **I authorize my health care surrogate to make my health care decisions,** which means (1) consenting, refusing to consent, or withdrawing consent to health care, including life-prolonging procedures, (2) applying for benefits to cover the cost of my health care, (3) accessing my health information to make health care decisions or apply for benefits, and (4) donating all or part of my body for transplantation, therapy, research, or education.

❒ _____ *(initial)* **Other specific instructions and restrictions (if any):** _____

_____

SIGNATURE

In order for this instrument to be valid, you must sign it in the presence of two witnesses, or if you are unable to sign this document yourself, you may, in the presence of the witnesses, direct that someone else sign this form on your behalf. The person you are appointing as your surrogate (or alternate surrogate) cannot serve as a witness, both witnesses must be adults, and at least one of the witnesses must be someone other than your spouse or blood relative.

Patient Name: _____
(print your name)

Signature: _____ Date Signed: _____

Witness #1:

Printed Name: _____

Address: _____

_____

Signature: _____

Date Signed: _____

Witness #2:

Printed Name: _____

Address: _____

_____

Signature: _____

Date Signed: _____

CHAPTERS HEALTH® SYSTEM

DESIGNATION OF HEALTH CARE SURROGATE

INSTRUCTIONS FOR REVOKING/AMENDING

While you are able, you may revoke or amend this designation by: (1) signing a document stating your intent to amend or revoke it, (2) destroying it (or having it destroyed in your presence and at your direction), (3) verbally amending or revoking it, or (4) signing a new designation that is different from this one. To ensure your revocation or amendment is effective, please immediately notify your surrogate(s) and health care providers.

WHAT SHOULD I DO WITH THIS FORM?

You must provide a copy of this form to your designated health care surrogate(s). It is recommended that you also provide a copy of this form to your physician, attorney, authorized representative, family, friends, significant other and caregiver.