

Florida Medical Power of Attorney

Governed by Fla. Stat. §§ 765.202–765.205 (Health Care Advance Directives)

IMPORTANT INFORMATION

IT IS IMPORTANT THAT YOU REVIEW THE FOLLOWING INFORMATION BEFORE YOU SIGN THIS DOCUMENT. READ THE INFORMATION CAREFULLY AND SEEK GUIDANCE FROM A HEALTHCARE PROFESSIONAL OR ATTORNEY IF YOU DO NOT UNDERSTAND ANY OF THE TERMS.

By signing this document, you are granting a designated person — your agent — the authority to make medical decisions on your behalf. These decisions may cover any medical service, treatment, procedure, or diagnosis, including decisions regarding physical and mental health conditions. Your agent will have the same decision-making authority you would have if you were able to act for yourself, including the authority to consent to, or refuse, medical treatment — up to and including decisions about withholding or withdrawing life-sustaining care. For this reason, it is essential that you choose someone you know well and trust completely, and that your agent understands your health care preferences.

Signing this document does not immediately transfer decision-making control. As long as you retain mental competence, you continue to direct your own health care. Your agent may only begin acting on your behalf after your physician has determined, in writing, that you are no longer able to make or communicate your own medical decisions.

Your designated agent must be at least eighteen years of age and must be someone you genuinely trust with your health and personal care. Your agent will not be held personally liable for decisions made in good faith on your behalf. Before executing this document, confirm that the person you have chosen is willing to serve as your agent, and discuss your medical wishes with them so they are fully prepared. You may also designate a backup agent to act if your primary agent is unable or unwilling to serve. Your backup agent should also be over 18 and informed of your health care preferences.

You may revoke this document at any time while you remain competent to do so, either by notifying your medical provider and agent verbally or by delivering a written revocation. Executing a later medical power of attorney will also serve to revoke this document.

For this document to be legally valid, it must be signed either before a notary public or in the presence of two competent adult witnesses who are at least 18 years of age, are not your agent, and are not related to your agent.

I. APPOINTMENT OF HEALTH CARE AGENT

I, _____ (Principal's Full Name) of

(Principal's Street Address), City of
_____, State of

(HEREINAFTER known as the "Principal") hereby appoint,

(Agent's Full Name) of

(Agent's Street Address), City of
_____, State of

(HEREINAFTER known as the "Agent") as my Agent to make any and all medical decisions on my behalf, except to the extent I limit those decisions in this document. This power of attorney takes effect if my doctor certifies in writing that I can no longer make my own health care decisions. My agent can be reached at the following contact information:

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

II. LIMITATIONS ON MY AGENT

My agent is authorized to make all medical decisions on my behalf EXCEPT for the following:

III. APPOINTMENT OF ALTERNATE AGENT

If my agent appointed above is unable or unwilling to serve as my agent, I appoint the following person(s) to serve as agents in the order set forth below with the authority to make health care decisions on my behalf as provided herein:

A. First Alternate Agent

Name: _____

Address: _____

Phone: _____

B. Second Alternate Agent

Name:

Address:

Phone:

IV. ORIGINAL AND COPIES OF THIS DOCUMENT

The original document is/will be filed in the following place:

I have/will provided copies of my medical power of attorney to the following:

V. DURATION

Unless stated otherwise herein, this document shall remain in effect until I revoke it. I understand that I cannot revoke this document during the time I am considered incompetent to make my own decisions.

(If applicable Initial and Check)

(OPTIONAL) This power of attorney shall expire on _____ day
of _____, 20_____.

VI. PRIOR MEDICAL POWER OF ATTORNEY

By signing this document, I hereby revoke any and all prior medical powers of attorney that I may have executed.

VII. EXECUTION

YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC

OR

YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES NOT RELATED BY BLOOD OR MARRIAGE.

Signature:

Print Name:

Date:

Address:

SIGNATURE OF SECOND WITNESS

Signature:

Print Name:

Date:

Address: