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How to Complete Your Florida Designation of Health Care Surrogate

Designation of Health Care Surrogate (Section 765.203, Florida Statutes)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. This is Florida's suggested statutory form for naming a health care surrogate, the person who makes **medical decisions** for you and can receive your health information. It does **not** cover financial matters. For finances, use a Florida Durable Power of Attorney.

1. **Name your surrogate and an alternate**
   Enter your name, then the name, address, and phone number of the person you want to make health care decisions for you, and an alternate.
2. **Initial the authority you want to give**
   Initial next to receiving your health information and next to making health care decisions. Add any specific instructions or restrictions and initial them.
3. **Decide when it takes effect**
   Unless you initial one or both of the boxes near the end, your surrogate's authority begins only when your primary physician determines you cannot make your own decisions.
4. **Sign in front of two witnesses and a notary**
   Do not sign or date the form ahead of time. Florida requires two adult witnesses, and at least one may not be your spouse or a blood relative. Your surrogate cannot be a witness. First Choice can provide witnesses for an additional fee, and our notary completes the acknowledgment.
5. **Bring identification**
   Bring a current, government-issued photo ID, such as a driver license, state ID, or passport.

After It's Signed

- Give an exact copy to your surrogate and alternate, and to your doctor and hospital so it can go in your medical records. Keep the original in a safe, easy-to-find place.
- You may revoke or change this designation at any time while you have capacity. We have a free Revocation of Advance Directive form.
- Consider also signing a Florida Living Will, which states your wishes about life-prolonging procedures.

Need a Notary and Witnesses? We Come to You.

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Witnesses available for an additional fee
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Have questions about this document? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**. Main headquarters: 2315 Capitol Avenue, Sacramento, CA 95816.

This form is provided as a free convenience. First Choice Mobile Notary & Apostille is not a law firm, and a notary public who is not an attorney cannot give legal advice or help you decide what to write on this form. These instructions are general information only and are not legal advice. If you have questions about your situation, consult a licensed Florida attorney. © 2026 First Choice Mobile Notary & Apostille. All rights reserved. This form may be filled in and printed for personal use; it may not be copied, altered, or redistributed for commercial purposes.

DESIGNATION OF HEALTH CARE SURROGATE

(Section 765.203, Florida Statutes)

I, (name), designate as my health care surrogate under s. 765.202, Florida Statutes:

Name of health care surrogate

Telephone

Address

If my health care surrogate is not willing, able, or reasonably available to perform his or her duties, I designate as my alternate health care surrogate:

Name of alternate health care surrogate

Telephone

Address

INSTRUCTIONS FOR HEALTH CARE

I authorize my health care surrogate to:

☐ Receive any of my health information, whether oral or recorded in any form or medium, 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 past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

I further authorize my health care surrogate to:

☐ Make all health care decisions for me, which means he or she has the authority to:
1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
2. Apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.
3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
4. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.

☐ Specific instructions and restrictions:

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While I have decisionmaking capacity, my wishes are controlling and my physicians and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.

To the extent I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

THIS HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES.

PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND THIS DESIGNATION BY:

(1) SIGNING A WRITTEN AND DATED INSTRUMENT WHICH EXPRESSES MY INTENT TO AMEND OR REVOKE THIS DESIGNATION;

(2) PHYSICALLY DESTROYING THIS DESIGNATION THROUGH MY OWN ACTION OR BY THAT OF ANOTHER PERSON IN MY PRESENCE AND UNDER MY DIRECTION;

(3) VERBALLY EXPRESSING MY INTENTION TO AMEND OR REVOKE THIS DESIGNATION; OR

(4) SIGNING A NEW DESIGNATION THAT IS MATERIALLY DIFFERENT FROM THIS DESIGNATION.

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 INITIAL EITHER OR BOTH OF THE FOLLOWING BOXES:

☐ **IF I INITIAL THIS BOX, MY HEALTH CARE SURROGATE'S AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECT IMMEDIATELY.**

☐ **IF I INITIAL THIS BOX, MY HEALTH CARE SURROGATE'S AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME TAKES EFFECT IMMEDIATELY. PURSUANT TO SECTION 765.204(3), FLORIDA STATUTES, ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY SHALL SUPERSEDE ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE THAT ARE IN MATERIAL CONFLICT WITH THOSE MADE BY ME.**

SIGNATURES: Sign and date the form here:

Date

X _____
Sign your name

Print your name

Address

City

State

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SIGNATURES OF WITNESSES

Witness rules (section 765.202, Florida Statutes): Two adult witnesses must sign in the presence of the principal and of each other. At least one witness must be neither the principal's spouse nor a blood relative. The person designated as surrogate may not act as a witness.

Signed by the principal in our presence, and we, the undersigned witnesses, have signed below in the presence of the principal and of each other.

Witness 1

X _____

Signature of witness

Printed name

Address (street, city, state, ZIP)

Date

Witness 2

X _____

Signature of witness

Printed name

Address (street, city, state, ZIP)

Date

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NOTARIZATION

Having this document notarized, in addition to the two witnesses, provides proof that the signature is genuine, which helps when the document is presented to hospitals, out-of-state providers, or other institutions.

NOTARY ACKNOWLEDGMENT

State of _____ County of _____

The foregoing instrument was acknowledged before me by means of

☐ physical presence or

☐ online notarization,

this day of _____ month _____ year _____

by (name of principal) _____

☐ Personally Known OR

☐ Produced Identification

Type of identification produced _____

X _____

Signature of Notary Public

Print, type, or stamp commissioned name of Notary Public _____

Commission number _____ Commission expires _____

(Notary seal)

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