Triage Cancer Estate Planning Toolkit: Florida

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Florida probate courts accept written and electronic wills. To make a valid written will in Florida:

1. You need to be in the right state of mind to create a will. This means you need to be:
    - At least 18 years old or an emancipated minor
    - Of "sound mind" (meaning you know what you're doing)
2. Your will must be written and signed in front of two adult witnesses.
3. Your will does not need to be notarized to be legal in Florida. But, you can make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, sign an affidavit in front of a notary to prove your identity and that all parties had knowledge of the will.

Florida does not accept holographic (handwritten), or oral wills.

To make a valid electronic will in Florida:

1. Your will must meet the requirements for a written will. However, the will itself and the signatures may be done electronically.
2. The witnesses may be present physically or electronically if they are supervised and authenticated by a notary.
3. You can make your electronic will self-proving by acknowledging the will and having affidavits from the witnesses.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

Florida's durable power of attorney form allows you to appoint someone to manage your finances, including assets like your property, taxes, and government benefits. You can also appoint an alternate agent in case the first person cannot act. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. Unless you indicate otherwise in the "special instructions" section, this document takes effect immediately after you sign it, and will remain in effect if you become incapacitated. This document will remain in effect until you die or revoke your power of attorney.

Part III of this toolkit includes a sample form.

State Laws About Advance Directives for Health Care

An advance health care directive (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. In Florida, this document includes three parts. You can complete part one and/or part two, but you must sign part three to make the document valid.

1. **Florida Designation of Health Care Surrogate:** You can appoint someone to make any and all health care decisions for you, including decisions about life-prolonging care, if your doctor determines you can no longer make these decisions yourself for any reason. You can also choose an alternate person if the first person you appoint is not available.
2. **Florida Living Will:** You can use a living will to express your wishes for your medical care in the event you become seriously ill or unconscious. You can also provide instructions for specific situations, including administering or withholding cardiopulmonary resuscitation, artificial respiration, artificially administered nutrition (food offered through surgically-placed tubes), comfort or pain management therapy, and any other instructions you would like to include. You can also indicate your preferences for organ donation with this document.
3. **Execution:** You and two witnesses must sign your AHCD to make it valid. Your surrogate and alternate surrogate cannot act as witnesses, and one of your witnesses cannot be a blood relative or spouse.

If you change your mind about the decisions you made in this document, you can revoke it orally, in writing, by destroying the document, or by validly executing a new AHCD. You must also notify your doctor and your agent that you have revoked your AHCD.

If you appoint your spouse as your agent, this will be automatically revoked if your marriage dissolves.

If you would like your surrogate to be able to withhold life-prolonging treatment while you are pregnant, insert the line ""My surrogate has the authority to order the withholding or withdrawal of life-prolonging treatment, even if I am pregnant," in the "Additional Instructions" section.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. The POLST does not replace an advance health care directive. You can complete a POLST form with your doctor. In Florida, this form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (also known as a "Do not resuscitate," or DNR order)
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Medically assisted nutrition, or food offered through surgically-placed tubes
- Additional orders or instructions for your care
- Hospice or palliative care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Florida does not have a funeral designation form. However, FL law does recognize your right to designate your own funeral arrangements when written down. There is no express authority allowing you to authorize an individual to carry out those wishes, but that is something that you could include in your will.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

Florida does not have a death with dignity law. But, you can indicate other decisions related to end-of-life care through an advance health care directive.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

Triage Cancer Estate Planning Toolkit: Florida

Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Physician Order for Life-Sustaining Treatment (POLST)
- HIPAA Authorization Form

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Part III: Your State's Estate Planning Forms

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Power of Attorney for Financial Affairs

FLORIDA GENERAL DURABLE POWER OF ATTORNEY

THE POWERS YOU GRANT BELOW ARE EFFECTIVE EVEN IF YOU BECOME DISABLED OR INCOMPETENT

This durable power of attorney is not affected by subsequent incapacity of the principal except as provided in §709.08, Florida Statutes.

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE UNIFORM STATUTORY FORM POWER OF ATTORNEY ACT. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL AND OTHER HEALTH-CARE DECISIONS FOR YOU. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO.

I _____
_____ [insert your name and address] appoint
_____ [insert the name and address of the person appointed] as my Agent (attorney-in-fact) to act for me in any lawful way with respect to the following initialed subjects:

TO GRANT ALL OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF (N) AND IGNORE THE LINES IN FRONT OF THE OTHER POWERS.

TO GRANT ONE OR MORE, BUT FEWER THAN ALL, OF THE FOLLOWING POWERS, INITIAL THE LINE IN FRONT OF EACH POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF IT. YOU MAY, BUT NEED NOT, CROSS OUT EACH POWER WITHHELD.

Note: If you initial Item A or Item B, which follow, a notarized signature will be required on behalf of the Principal.

INITIAL

_____ **(A) Real property transactions.** To lease, sell, mortgage, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, sale, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any interest in real property whatsoever, on such terms and conditions, and under such covenants, as my Agent shall deem proper; and to maintain, repair, tear down, alter, rebuild, improve manage, insure, move, rent, lease, sell, convey, subject to liens, mortgages, and security deeds, and in any way or manner deal with all or any part of any interest in real property whatsoever, including specifically, but without limitation, real property lying and being situated in the State of Florida, under such terms and conditions, and under such covenants, as my Agent shall deem proper and may for all deferred payments accept purchase money notes payable to me and secured by mortgages or deeds to secure debt, and may from time to time collect and cancel any of said notes, mortgages, security interests, or deeds to secure debt.

_____ **(B) Tangible personal property transactions.** To lease, sell, mortgage, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, sale, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any personal property whatsoever, tangible or intangible, or interest thereto, on such terms and conditions, and under such covenants, as my Agent shall deem proper; and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens or mortgages, or to take any other security interests in said property which are recognized under the Uniform Commercial Code as adopted at that time under the laws of the State of Florida or any applicable state, or otherwise hypothecate (pledge), and in any way or manner deal with all or any part of any real or personal property whatsoever, tangible or intangible, or any interest therein, that I own at the time of execution or may thereafter acquire, under such terms and conditions, and under such covenants, as my Agent shall deem proper.

_____ **(C) Stock and bond transactions.** To purchase, sell, exchange, surrender, assign, redeem, vote at any meeting, or otherwise transfer any and all shares of stock, bonds, or other securities in any business,

association, corporation, partnership, or other legal entity, whether private or public, now or hereafter belonging to me.

_____ **(D) Commodity and option transactions.** To buy, sell, exchange, assign, convey, settle and exercise commodities futures contracts and call and put options on stocks and stock indices traded on a regulated options exchange and collect and receipt for all proceeds of any such transactions; establish or continue option accounts for the principal with any securities or futures broker; and, in general, exercise all powers with respect to commodities and options which the principal could if present and under no disability.

_____ **(E) Banking and other financial institution transactions.** To make, receive, sign, endorse, execute, acknowledge, deliver and possess checks, drafts, bills of exchange, letters of credit, notes, stock certificates, withdrawal receipts and deposit instruments relating to accounts or deposits in, or certificates of deposit of banks, savings and loans, credit unions, or other institutions or associations. To pay all sums of money, at any time or times, that may hereafter be owing by me upon any account, bill of exchange, check, draft, purchase, contract, note, or trade acceptance made, executed, endorsed, accepted, and delivered by me or for me in my name, by my Agent. To borrow from time to time such sums of money as my Agent may deem proper and execute promissory notes, security deeds or agreements, financing statements, or other security instruments in such form as the lender may request and renew said notes and security instruments from time to time in whole or in part. To have free access at any time or times to any safe deposit box or vault to which I might have access.

_____ **(F) Business operating transactions.** To conduct, engage in, and otherwise transact the affairs of any and all lawful business ventures of whatever nature or kind that I may now or hereafter be involved in. To organize or continue and conduct any business which term includes, without limitation, any farming, manufacturing, service, mining, retailing or other type of business operation in any form, whether as a proprietorship, joint venture, partnership, corporation, trust or other legal entity; operate, buy, sell, expand, contract, terminate or liquidate any business; direct, control, supervise, manage or participate in the operation of any business and engage, compensate and discharge business managers, employees, agents, attorneys, accountants and consultants; and, in general, exercise all powers with respect to business interests and operations which the principal could if present and under no disability.

_____ **(G) Insurance and annuity transactions.** To exercise or perform any act, power, duty, right, or obligation, in regard to any contract of life, accident, health, disability, liability, or other type of insurance or any combination of insurance; and to procure new or additional contracts of insurance for me and to designate the beneficiary of same; provided, however, that my Agent cannot designate himself or herself as beneficiary of any such insurance contracts.

_____ **(H) Estate, trust, and other beneficiary transactions.** To accept, receipt for, exercise, release, reject, renounce, assign, disclaim, demand, sue for, claim and recover any legacy, bequest, devise, gift or other property interest or payment due or payable to or for the principal; assert any interest in and exercise any power over any trust, estate or property subject to fiduciary control; establish a revocable trust solely for the benefit of the principal that terminates at the death of the principal and is then distributable to the legal representative of the estate of the principal; and, in general, exercise all powers with respect to estates and trusts which the principal could exercise if present and under no disability; provided, however, that the Agent may not make or change a will and may not revoke or amend a trust revocable or amendable by the principal or require the trustee of any trust for the benefit of the principal to pay income or principal to the Agent unless specific authority to that end is given.

_____ **(I) Claims and litigation.** To commence, prosecute, discontinue, or defend all actions or other legal proceedings touching my property, real or personal, or any part thereof, or touching any matter in which I or my property, real or personal, may be in any way concerned. To defend, settle, adjust, make allowances, compound, submit to arbitration, and compromise all accounts, reckonings, claims, and demands whatsoever that now are, or hereafter shall be, pending between me and any person, firm, corporation, or other legal entity, in such manner and in all respects as my Agent shall deem proper.

_____ **(J) Personal and family maintenance.** To hire accountants, attorneys at law, consultants, clerks, physicians, nurses, agents, servants, workmen, and others and to remove them, and to appoint others in their place, and to pay and allow the persons so employed such salaries, wages, or other remunerations, as my Agent shall deem proper.

_____ **(K) Benefits from Social Security, Medicare, Medicaid, or other governmental programs, or military service.** To prepare, sign and file any claim or application for Social Security, unemployment or

military service benefits; sue for, settle or abandon any claims to any benefit or assistance under any federal, state, local or foreign statute or regulation; control, deposit to any account, collect, receipt for, and take title to and hold all benefits under any Social Security, unemployment, military service or other state, federal, local or foreign statute or regulation; and, in general, exercise all powers with respect to Social Security, unemployment, military service, and governmental benefits, including but not limited to Medicare and Medicaid, which the principal could exercise if present and under no disability.

_____ **(L) Retirement plan transactions.** To contribute to, withdraw from and deposit funds in any type of retirement plan (which term includes, without limitation, any tax qualified or nonqualified pension, profit sharing, stock bonus, employee savings and other retirement plan, individual retirement account, deferred compensation plan and any other type of employee benefit plan); select and change payment options for the principal under any retirement plan; make rollover contributions from any retirement plan to other retirement plans or individual retirement accounts; exercise all investment powers available under any type of self-directed retirement plan; and, in general, exercise all powers with respect to retirement plans and retirement plan account balances which the principal could if present and under no disability.

_____ **(M) Tax matters.** To prepare, to make elections, to execute and to file all tax, social security, unemployment insurance, and informational returns required by the laws of the United States, or of any state or subdivision thereof, or of any foreign government; to prepare, to execute, and to file all other papers and instruments which the Agent shall think to be desirable or necessary for safeguarding of me against excess or illegal taxation or against penalties imposed for claimed violation of any law or other governmental regulation; and to pay, to compromise, or to contest or to apply for refunds in connection with any taxes or assessments for which I am or may be liable.

_____ **(N) ALL OF THE POWERS LISTED ABOVE.** YOU NEED NOT INITIAL ANY OTHER LINES IF YOU INITIAL LINE (N).

SPECIAL INSTRUCTIONS:

ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS GRANTED TO YOUR AGENT.

_____

_____

_____

_____

_____

_____

_____

THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT IS REVOKED.

THIS POWER OF ATTORNEY SHALL BE CONSTRUED AS A GENERAL DURABLE POWER OF ATTORNEY AND SHALL CONTINUE TO BE EFFECTIVE EVEN IF I BECOME DISABLED, INCAPACITATED, OR INCOMPETENT.

(YOUR AGENT WILL HAVE AUTHORITY TO EMPLOY OTHER PERSONS AS NECESSARY TO ENABLE THE AGENT TO PROPERLY EXERCISE THE POWERS GRANTED IN THIS FORM, BUT YOUR AGENT WILL HAVE TO MAKE ALL DISCRETIONARY DECISIONS. IF YOU WANT TO GIVE YOUR AGENT THE RIGHT TO DELEGATE DISCRETIONARY DECISION-MAKING POWERS TO OTHERS, YOU SHOULD KEEP THE NEXT SENTENCE, OTHERWISE IT SHOULD BE STRICKEN.)

Authority to Delegate. My Agent shall have the right by written instrument to delegate any or all of the

foregoing powers involving discretionary decision-making to any person or persons whom my Agent may select, but such delegation may be amended or revoked by any agent (including any successor) named by me who is acting under this power of attorney at the time of reference.

(YOUR AGENT WILL BE ENTITLED TO REIMBURSEMENT FOR ALL REASONABLE EXPENSES INCURRED IN ACTING UNDER THIS POWER OF ATTORNEY. STRIKE OUT THE NEXT SENTENCE IF YOU DO NOT WANT YOUR AGENT TO ALSO BE ENTITLED TO REASONABLE COMPENSATION FOR SERVICES AS AGENT.)

Right to Compensation. My Agent shall be entitled to reasonable compensation for services rendered as agent under this power of attorney.

(IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAME(S) AND ADDRESS(ES) OF SUCH SUCCESSOR(S) IN THE FOLLOWING PARAGRAPH.)

Successor Agent. If any Agent named by me shall die, become incompetent, resign or refuse to accept the office of Agent, I name the following (each to act alone and successively, in the order named) as successor(s) to such Agent:

_____

_____

Choice of Law. THIS POWER OF ATTORNEY WILL BE GOVERNED BY THE LAWS OF THE STATE OF FLORIDA WITHOUT REGARD FOR CONFLICTS OF LAWS PRINCIPLES. IT WAS EXECUTED IN THE STATE OF FLORIDA AND IS INTENDED TO BE VALID IN ALL JURISDICTIONS OF THE UNITED STATES OF AMERICA AND ALL FOREIGN NATIONS.

I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my Agent.

I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party learns of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

Signed this _____ day of _____, 20____

_____
[Your Signature]

STATEMENT OF WITNESS

On the date written above, the principal declared to me in my presence that this instrument is his general durable power of attorney and that he or she had willingly signed or directed another to sign for him or her, and that he or she executed it as his or her free and voluntary act for the purposes therein expressed.

_____ [Signature of Witness #1]
_____ [Printed or typed name of Witness #1]
_____ [Address of Witness #1, Line 1]
_____ [Address of Witness #1, Line 2]

_____ [Signature of Witness #2]
_____ [Printed or typed name of Witness #2]

_____ [Address of Witness #2, Line 1]
_____ [Address of Witness #2, Line 2]

A Note About Selecting Witnesses: The agent (attorney-in-fact) may not also serve as a witness. Each witness must be present at the time that principal signs the Power of Attorney in front of the notary. Each witness must be a mentally competent adult. Witnesses should ideally reside close by, so that they will be easily accessible in the event they are one day needed to affirm this document's validity.

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF FLORIDA
COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this _____day of _____ [month], _____ [year] by _____ [name of principal]. The affiant is [choose one:] ____ personally known to me, or ____ produced the following identification: _____.

[Notary Seal, if any]:

_____
(Signature of Notarial Officer)

Notary Public for the State of Florida

My commission expires: _____

ACKNOWLEDGMENT OF AGENT

BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, THE AGENT ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.

_____
[Typed or Printed Name of Agent]

_____
[Signature of Agent]

PREPARATION STATEMENT

This document was prepared by the following individual:

_____
[Typed or Printed Name]

_____
[Signature]

AFFIDAVIT OF AGENT (ATTORNEY IN FACT)

STATE OF FLORIDA
COUNTY OF _____

Before me, the undersigned authority, personally appeared _____ _____ (attorney in fact), ("Affiant"), who swore or affirmed that:

1. Affiant is the attorney in fact named in the Florida General Durable Power of Attorney executed by _____ (principal) ("Principal") on _____ (date).

2. This Florida General Durable Power of Attorney is currently exercisable by Affiant. The principal is domiciled in _____ (insert name of state, territory, or foreign country).

3. To the best of the Affiant's knowledge after diligent search and inquiry:

a. The Principal is not deceased; and

b. There has been no revocation, partial or complete termination by adjudication of incapacity or by the occurrence of an event referenced in the durable power of attorney, or suspension by initiation of proceedings to determine incapacity or to appoint a guardian.

4. Affiant agrees not to exercise any powers granted by the Florida General Durable Power of Attorney if Affiant attains knowledge that it has been revoked, partially or completely terminated, suspended, or is no longer valid because of the death or adjudication of incapacity of the Principal.

_____
[Signature of Affiant]

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

Sworn to (or affirmed) and subscribed before me this _____day of _____ [month], _____ [year] by _____ [name of agent]. The affiant is [*choose one:*] ____ personally known to me, or ____ produced the following identification: _____.

[Notary Seal, if any]:

_____
(Signature of Notarial Officer)

Notary Public for the State of Florida

My commission expires: _____

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Part III: Your State's Estate Planning Forms

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Advance Health Care Directive

INSTRUCTIONS

PRINT YOUR NAME

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR SURROGATE

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE SURROGATE

Part One. Designation of Health Care Surrogate

Name: _____
(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: _____

_____ Zip Code: _____

Phone: _____

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

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

When making health care decisions for me, my health care surrogate should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Two (if I have filled out Part Two), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care surrogate should make decisions for me that my health care surrogate believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

FLORIDA ADVANCE DIRECTIVE - PAGE 2 OF 5

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Additional instructions (optional):

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

INITIAL EACH THAT APPLIES

Part Two. Declaration

Declaration made this_____ day of_____,_____,
(day) (month) (year)

I,_____,
willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that:

If at any time I am incapacitated and

(initial all that apply)

_____ I have a terminal condition, or

_____ I have an end-stage condition, or

_____ I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

My failure to designate a health care surrogate in Part One shall not invalidate this declaration.

ORGAN DONATION (OPTIONAL)

INITIAL ONLY ONE OF THE FOUR OPTIONS

IF YOU HAVE ALREADY ARRANGED TO DONATE YOUR ORGANS TO A SPECIFIC DONEE, INITIAL THIS OPTION, AND INDICATE THE DETAILS OF YOUR ARRANGEMENT HERE

ORGAN DONATION (OPTIONAL)

I hereby make this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give (initial one choice below):

_____ any needed organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education;

_____ only the following organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education:

_____
_____
_____

_____ my body for anatomical study if needed. Limitations or special wishes, if any:

_____
_____
_____

_____I have already arranged to donate

_____ Any needed organs, tissues, or eyes,

_____ The following organs, tissues, or eyes:

_____
_____
_____

to the following donee:_____

Phone:_____

Address:_____

_____Zip Code:_____

Part Three. Execution

PRINT YOUR NAME

I,_____
understand the full impact of this declaration, and I am emotionally and mentally competent to make this declaration. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

SIGN AND DATE THE DOCUMENT

Signed: _____

Date: _____

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness 1:

Signed: _____

Address: _____

_____

Witness 2:

Signed: _____

Address: _____

_____

OPTIONAL

PRINT THE NAMES AND ADDRESSES OF THOSE WHO YOU WANT TO KEEP COPIES OF THIS DOCUMENT

(Optional) I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is:

Name: _____

Address: _____

_____

Name: _____

Address: _____

_____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

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Part III: Your State's Estate Planning Forms

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Physician Orders for Life Sustaining Treatment (POLST)

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Physician Orders for Life-Sustaining Treatment (POLST)-Florida

Follow these orders until orders are reviewed. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	Middle Int.

Date of Birth: (mm/dd/yyyy)	Gender	Last 4 SSN:
____ ____ ____	☐ M ☐ F	☐☐☐☐

If the patient has decision-making capacity, the patient's presently expressed wishes should guide his or her treatment

A — CARDIOPULMONARY RESUSCITATION (CPR): Patient is unresponsive, pulseless, and not breathing.

Check One

☐ **Attempt Resuscitation/CPR**

☐ **Do Not Attempt Resuscitation/DNR**

When not in cardiopulmonary arrest, follow orders in B and C.

B — MEDICAL INTERVENTIONS: If patient has pulse and is breathing.

Check One

☐ **Full Treatment – goal is to prolong life by all medically effective means.**
In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and /or intensive care unit if indicated.
Care Plan: Full treatment including life support measures in the intensive care unit.

☐ **Limited Medical Interventions – goal is to treat medical conditions but avoid burdensome measures**
In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP).
Transfer to hospital if indicated. Generally avoid the intensive care unit.
Care Plan: Provide basic medical treatments.

☐ **Comfort Measures Only (Allow Natural Death) – goal is to maximize comfort and avoid suffering**
Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. Consider hospice or palliative care referral if appropriate.**
Care Plan: Maximize comfort through symptom management.

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible.

Check One

☐ **Long-term artificial nutrition by tube**.

☐ **Defined trial period of artificial nutrition by tube.**

☐ **No artificial nutrition by tube.**

Additional Instructions: _____

D — HOSPICE or PALLIATIVE CARE (complete if applicable) - consider referral as appropriate

Check One

☐ Patient/Resident Currently enrolled in Hospice Care	☐ Patient/Resident Currently enrolled in Palliative Care	☐ Not indicated or refused
Contact: _____	Contact: _____	

SIGNATURES

Print Physician Name	MD/DO License #	Phone Number

Physician Signature **(mandatory)**	Date

Print Patient/Resident or Surrogate/Proxy Name	Relationship (write 'self' if patient)

Patient or Surrogate Signature **(mandatory)**	Date

SEND FORM WITH PATIENT WHENEVER TRANFERRED OR DISCHARGED

Use of original form is strongly encouraged. Photocopies and facsimiles of completed POLST are legal and valid.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

E Check All That Apply

DOCUMENTATION OF DISCUSSION:

☐ Patient (Patient has capacity) ☐ Health Care Representative or surrogate

☐ Parent of minor ☐ Court-Appointed Guardian ☐ Other (proxy)

Other Contact Information

Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number/Address	
Name of Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professionals

Completing POLST

- Must be completed by a health care professional based on medical indications, a discussion of treatment benefits and burdens, and elicitation of patient preferences.
- POLST must be signed by a MD/DO to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- POLST must be signed by patient/resident or healthcare surrogate/proxy to be valid.

Using POLST

- Any section of POLST not completed implies full treatment for that section.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation."
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with "comfort measures only," should be transferred to a setting able to provide comfort, such as a hospice unit.
- A person who chooses either "comfort measures only" or "limited additional interventions" should not be entered into a Level I trauma system.
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."
- A person with capacity or the surrogate/proxy (if patient lacks capacity) can revoke the POLST at any time and request alternative treatment.

Reviewing POLST

This POLST should be reviewed periodically and a new POLST completed if necessary when:

(1) The person is transferred from one care setting or care level to another, or

(2) There is a substantial change in the person's health status, or

(3) The person's treatment preferences change.

To void this form, draw line through sections A through D on page 1 and write "VOID" in large letters.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

REVISED FORM (JULY 10,2015)

Triage Cancer Estate Planning Toolkit

⌘

Part III: Your State's Estate Planning Forms

⌘

HIPAA Authorization Form

Sample HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):

    _____
    _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524