DECLARATION OF LIVING WILL

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

If at any time (i) I am incapacitated; and (ii) I have a end-stage terminal condition, or am in a persistent vegetative state; and (iii) my attending physician has determined that there is no reasonable probability of my recovery from such condition, where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me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.

Artificially provided nourishment and fluids:

____ I want a feeding tube and hydration.

____ I *DO NOT* want a feeding tube, hydration or other artificially-provided nutrition.

Authorization for Experimental Medical Treatment: If I am confronted by a life-threatening situation, and there is no alternative approved or generally-accepted method of treatment that is more likely to save my life, I specifically:

____ Authorize my doctors to use experimental drugs or medical procedures on me, but only as allowed by the rules of the U. S. Food and Drug Administration for medical experimentation on human subjects without their informed consent.

____ *DO NOT* authorize my doctors to use experimental drugs or medical procedures on me as allowed by the rules of the U. S. Food and Drug Administration for medical experimentation on human subjects without their informed consent.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal. I authorize the following agents to communicate for me on my behalf regarding this Living Will and make decisions on my behalf. The agents named below have the right to act inconsistently with this Living Will, provided he/she believes it is in my best interests.

1. _____, presently residing at

   _____

   _____

   _____(PHONE)

2. _____, presently residing at

   _____

   _____

   _____(PHONE)

This Living Will is executed by me with full awareness that the Florida Legislature has enacted the "Life-Prolonging Procedure Act of Florida" (hereinafter the "Act"), as set forth in Chapter 765, Florida Statutes. All terms used herein shall be given the same meaning and import as provided under the Act as it may be amended from time to time.

Organ Donor Certification:

____ I want to donate my organs and/or tissues for transplantation.

____ I want to donate any of my organs if they will be used immediately to save another's life.

____ I want to donate specifically my

_____

If I choose any of the above, my doctors may maintain me on artificial support systems only long enough to maintain the viability of and to remove such organs and/or tissues.

____ I *DO NOT* want to donate my organs or tissues for transplantation.

In addition to all other powers granted by this document, I grant to my agent the power and authority to serve as my personal representative for all purposes of the Health Insurance

Portability and Accountability Act of 1996 and its regulations ("HIPAA") during any time my health care representative is exercising authority under this document.

Pursuant to HIPAA, I designate the agents named above my HIPAA personal representative(s) and authorize my agents to request, receive and review any information regarding my physical or mental health, including, without limitation all HIPAA protected health information, medical and hospital records; to execute on my behalf any authorizations, release or other documents that may be required in order to obtain this information; and to consent to the disclosure of this information. I further authorize my agents to execute on my behalf any documents necessary or desirable to implement health care decisions pursuant to this document.

By signing this Declaration of Living Will, I specifically empower and authorize my physician, hospital or health care provider to release any and all medical records to my agent's designee. Further, I waive any liability to any physician, hospital or any health care provider who releases any and all of my medical records to my agent.

The authority given my agent shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

Dated: _____ _____

_____, Principal

The declarant is known to us and we believe the declarant to be of sound mind.

_____ _____

Signature of Witness Signature of Witness

_____ _____

Printed Name of Witness Printed Name of Witness

STATE OF FLORIDA
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who [ ] is personally known to me or who [ ] has produced_____ as identification and who did not take an oath.

_____
Notary Public
Print Name:

My commission expires: