2015 Legislative Amendments to Florida's Health Care Advance Directives Statute (with forms)

Effective October 1, 2015 statutory changes to Florida the Health Care Surrogate provisions take effect.

Effect of the Bill Health Care Surrogate for an Adult

The bill creates s. 765.202(6), F.S., to provide that an individual may elect to designate a health care surrogate who may act while the individual is still competent to make health care decisions. To that end, the bill:

- Adds a legislative finding at s. 765.102(3), F.S., that some competent adults want a health care surrogate to assist them with making medical decisions.
- Provides that statutory provisions for review of the decision of a health care surrogate at s. 765.105, F.S., do not apply when the individual who appointed the health care surrogate is still competent.
- Amends s. 765.204, F.S., which relates to determinations of incapacity, to require a health care facility to notify the surrogate upon a determination of incapacity. The notification requirement requires notice to the attorney in fact if the health care facility knows of a durable power of attorney. It also requires an attending physician's hospital to inform a principal's primary physician of the principal's incapacity, if an attending physician determines the principal lacks capacity.
- Provides that a health care provider is not liable for relying on a decision made by a surrogate while the principal lacks capacity.
- Provides that, where the principal has capacity and the decision of the principal conflicts with a decision of the surrogate, the decision of the principal controls.
- Authorizes an alternate health care surrogate to act when the primary surrogate is not reasonably available in addition to those circumstances when the primary surrogate is unwilling or unable to act.

The bill creates a sample form for the designation of a health care surrogate for an adult under s. 765.203, F.S. (See Attachment I).

Consent to Medical Treatment of a Minor; Creation of Health Care Surrogate for a Minor

In general, a minor does not have the legal right to consent to medical care or treatment. Instead, for non-emergency treatment, a parent or legal guardian must give consent. As to emergency treatment, where the parents, legal custodian or legal guardian of a minor cannot be timely contacted to give consent for medical treatment of a minor, s. 743.0645(2), F.S., sets forth a list of people who have the power to consent on behalf of the minor. There is no general statutory authority for non-emergency medical treatment of a minor without consent of a parent or legal guardian.

It is common for parents and legal guardians to go on vacation and leave their children with a caregiver, and equally common for parents and legal guardians to allow a minor to travel and stay with relatives or friends for a period of time. Lawyers routinely draft a power of attorney authorizing

caregivers to consent to medical treatment of the minor, despite there being no statutory authority for such document.

The bill amends s. 743.0645, F.S., to recognize that a power of attorney executed between July 1, 2001, and September 30, 2015, may authorize an individual to consent to health care for a minor. However, no power of attorney executed after the effective date of the bill, October 1, 2015, will be authority to consent to such treatment. Thus, after the effective date of the bill only a designation of health care surrogate will allow someone other than a parent, legal custodian or legal guardian to consent to non-emergency medical care of a minor.

The bill creates s. 765.2035, F.S., to create statutory authority for a parent, legal custodian or legal guardian to designate a health care surrogate who may consent to medical care for a minor. The designation must be in writing and signed by two witnesses. The designated surrogate may not be a witness. Like a surrogate for an adult, an alternate surrogate may be appointed to act if the original surrogate is not willing, able, or reasonably available to act.

In addition to regular and emergency treatment, a health care surrogate for a minor is authorized to consent to mental health treatment unless the document specifically provides otherwise. The appointment of a health care surrogate for a minor remains in place until the termination date provided in the designation (if any), the minor reaches the age of majority, or the designation is revoked.

The bill also creates a sample form for the designation of a health care surrogate for a minor under s. 765.2038, F.S. (See Attachment II).

Other

The bill amends ss. 765.101 and 765.202, F.S., to specify that a right to consent to treatment of an individual (adult or minor) also includes the right to obtain health information regarding that individual

The bill creates s. 765.101(9), F.S., to define the term “health information” to be consistent with the Health Insurance Portability and Accountability Act.

The bill removes the majority of references to “attending physician” in favor of the term “primary physician”, “evaluating physician” or simply “physician” in statutes related to advance directives, health care surrogates, pain management, palliative care, capacity, living wills, determination of patient condition, persistent vegetative state, and anatomical gifts. This change in terminology should have no practical effect.

The bill defines attending physician as the physician who has primary responsibility for the treatment and care of the patient while the patient receives such treatment or care in a hospital as defined in s. 395.002(12), F.S.

The bill has an effective date of October 1, 2015

DESIGNATION OF HEALTH CARE SURROGATE

I, _____, designate as my health care surrogate under s. 765.202, Florida Statutes:

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

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, individually in the order named:

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

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.

"Health information" means any information, whether oral or recorded in any form or medium, as defined in 45 C.F.R. s. 160.103 and the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. s. 1320d, as amended, that:

(a) 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

(b) Relates to the past, present, or future physical or mental health or condition of the principal; the provision of health care to the principal; or the past, present, or future payment for the provision of health care to the principal.

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: None

While I have decision making 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.

This designation of health care surrogate is executed by me on _____, 2015.

_____

Name: _____

This designation of health care surrogate is witnessed by us in the presence of the declarant.

_____	_____
Witness: _____	Witness: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____

STATE OF FLORIDA
COUNTY OF ALACHUA

The foregoing instrument was acknowledged before me on _____, 2015, by _____.

_____

Notary Public--State of Florida

Personally Known _____	Print Notary Name: _____
Produced Identification x	My Commission Number is: _____
Type of Identification Florida Driver License	My Commission Expires: _____

DESIGNATION OF HEALTH CARE SURROGATE FOR MINOR CHILD

I, _____, the [_____] natural guardian as defined in s. 744.301(1), Florida Statutes; [_____] legal custodian; [_____] legal guardian [check one] of the following minor(s):

_____; DOB: _____

_____; DOB: _____

_____, DOB: _____

pursuant to s. 765.2035, Florida Statutes, designate the following person to act as my/our surrogate for health care decisions for such minor(s) in the event that I am not able or reasonably available to provide consent for medical treatment and surgical and diagnostic procedures:

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

If my designated health care surrogate for a minor is not willing, able, or reasonably available to perform his or her duties, I designate the following person as my alternate health care surrogate for a minor, individually in the order named:

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

I authorize and request all physicians, hospitals, or other providers of medical services to follow the instructions of my surrogate or alternate surrogate, as the case may be, at any time and under any

circumstances whatsoever, with regard to medical treatment and surgical and diagnostic procedures for a minor, provided the medical care and treatment of any minor is on the advice of a licensed physician.

I fully understand that this designation will permit my designee to make health care decisions for a minor 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 the admission or transfer of a minor to or from a health care facility.

I will notify and send a copy of this document to the following person(s) other than my surrogate, so that they may know the identity of my surrogate:

Name: _____

Name: _____

Signed: _____ (signature)

This designation of health care surrogate for minor child is executed by me on _____, 2015.

_____
Name _____

This designation of health care surrogate is witnessed by us in the presence of the declarant.

_____	_____
Witness: _____	Witness: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____

STATE OF FLORIDA
COUNTY OF ALACHUA

The foregoing instrument was acknowledged before me on _____, 2015, by _____.

_____
Notary Public--State of Florida

Personally Known _____
Produced Identification x
Type of Identification Florida Driver License

Print Notary Name: _____
My Commission Number is: _____
My Commission Expires: _____