COUNTRYSIDE MEDICAL
Dr. Kenneth Lee
7860 SW 103rd St. Rd. • Bldg. 100, Ste. 101 • Ocala, Florida 34476
(352) 873-4458

Dear Patient: .

Florida Statutes require that we provide our patients with information concerning their rights to a living will and/or advance directive.

An ADVANCE DIRECTIVE is a witnessed statement made by a competent adult regarding his/her wishes or desires regarding future health care (for example - Provide artificial life support).

A LIVING WILL is a formalized version of an ADVANCE DIRECTIVE.

Please take this information home and carefully review it. If you wish to execute an advance directive or living will, please notify this office on the next visit.

Sincerely,

Cheryl Lee, RN

Cheryl Lee, RN
Administrator

LIVING WILL

Declaration made this _____day of _____20____, willfully and voluntarily make known by desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If at any time, I have a terminal condition and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying and that I be permitted to die naturally with only the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 I accept the consequences of such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

I understand the full import of this declaration, and am emotionally and mentally competent to make this declaration.

Additional instructions (optional): _____

_____

_____

_____

Signed: _____

Witness: _____

Address: _____

City/State/Zip: _____

Phone: _____

Witness: _____

Address: _____

City/State/Zip: _____

Phone: _____

I have received a copy of Health Care Directives and understand my rights relating to advance directives and living wills.

☐ I do not have a living will. ☐ I do have a living will. Please provide copy.

DESIGNATION OF A HEALTH CARE SURROGATE

Name (full): _____

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: _____

City/State/Zip: _____ Phone: _____

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

Name: _____

Address: _____

City/State/Zip: _____ 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.

Additional instructions: _____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. 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: _____ Name: _____

Signed: _____ Date: _____

Witness: _____ Witness: _____