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Hilo Medical Center
We Care for Our Community

DECLARATION OF AUTHORITY TO ACT AS SURROGATE

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I, _____ ,
(Print or Type Name of Surrogate)
under penalty of false swearing, provide the following statement of facts and circumstances establishing my claimed authority to act as a surrogate for

_____ .
(Print or Type Name of Patient/Resident)

To the best of my knowledge and belief, the patient/resident named above has been determined by the supervising health care provider to lack capacity to make healthcare decisions, and no agent or guardian has been appointed or the agent or guardian is not reasonably available.

THIS SECTION TO BE COMPLETED AND SIGNED ONLY BY PATIENT/RESIDENT DESIGNATED SURROGATE:

I have been provided information that the above named patient/resident personally informed the supervising health care provider that I have been designated by the patient to make health care decisions for the patient as his or her surrogate. This information was provided to me by the following means:

_____
(e.g., orally by (name of supervising health care provider – supervising health care provider/designee, health care provider/designee); by letter dated _____ (copy attached); as recorded in patient's health care record, etc.)

I accept the appointment as a "patient-designated surrogate" for the patient/resident.

_____ _____
(Signature of Patient/Resident Designated Surrogate *(Date)*

_____
(Printed Name)

_____
(Address) *(City)* *(State)* *(Zip code)*