DESIGNATION OF RESIDENT ADVOCATE

I, _____, authorize _____, a fellow resident of Heritage on the Marina, to be my advocate when I receive care from a health provider. My advocate may:

☐ Communicate my personal and social needs to my caregivers.

☐ Give my caregivers information about my background, lifestyle, attitudes, preferred routines, likes, and dislikes.

☐ Visit me and bring me items I need.

☐ Suggest non-medical items and services that may help with my care, based on my advocate's knowledge of my likes and dislikes.

I understand my advocate may receive certain health information about me from Heritage on the Marina or from another health provider. This information must be related directly to my advocate's involvement in my care.* The provider (such as a skilled nursing facility, a doctor, or Heritage on the Marina) will decide, in its professional judgment, what information to share with my advocate.

I also understand that my advocate cannot disclose medical information he or she receives about me to others without my express permission or the express permission of my agent under a durable power of attorney ("DPA") or an advance health care directive ("AHCD").

Finally, I understand that an advocate is not the same as an agent under a DPA or AHCD. My advocate does not make decisions about my care or my affairs. These decisions will be made by me as long as I have the capacity to make decisions on my own behalf and until my agent's powers are triggered under my DPA or AHCD.

I have read this form and understand my advocate's rights and powers.

_____ _____

Signature of Resident Date

_____

Printed Name

I have read this form will abide by its terms when I act as an advocate.

_____ _____

Signature of Advocate Date

_____

Printed Name

* My advocate can also receive information if he or she is responsible for payment for my care. We recognize that this seldom applies to resident advocates at Heritage on the Marina.