DESIGNATION OF RESIDENT ADVOCATE

I, _____, authorize _____, a fellow resident of Heritage on the Marina, to serve as my advocate in the event I receive care from a health provider. In this capacity, my advocate may:

☐ Communicate my personal and social needs to my caregivers.

☐ Assist my caregivers by providing them with 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 might assist in my care, based on my advocate's knowledge of my likes and dislikes.

I understand that my advocate may receive certain health information about me from Heritage on the Marina or from another health provider. Such information must be directly relevant to my advocate's involvement in my care or the payment for my care. The provider (such as a skilled nursing facility, a physician, or Heritage on the Marina) will determine, in its professional judgment, what information to share with my advocate.

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

Finally, I understand that my advocate's role is distinct from the role of my agent (if any) under a DPA or AHCD. My advocate is not empowered to make decisions about my care or affairs. Such 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 the scope of my advocate's rights and powers.

_____ _____

Signature of Resident Date

_____

Printed Name

I have read this form will perform my duties as advocate in accordance with its terms.

_____ _____

Signature of Advocate Date

_____

Printed Name