Medical Power of Attorney

Personal Information

Full Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Healthcare Agent

I appoint the following person to make healthcare decisions for me if I cannot do so.

Agent Name: _____

Relationship: _____

Phone: _____

Address: _____

Alternate Agent (Optional)

Name: _____

Relationship: _____

Phone: _____

Authority

My healthcare agent may:

☐ Talk with my doctors

☐ Approve or refuse treatment

☐ Access my medical records

☐ Choose healthcare facilities

Special Instructions

_____

_____

Signature

Signature: _____

Date: _____

Witnesses

Witness 1: _____

Signature: _____

Date: _____

Witness 2: _____

Signature: _____

Date: _____

Notary (If Required)

Notary Signature: _____

Date: _____

Seal: _____