Durable Medical Proxy

Patient Name: [Patient's Full Name]

Date of Birth: [Patient's Date of Birth]

Address: [Patient's Address]

Designation of Health Care Agent

I, [Patient's Full Name], hereby appoint:

Agent Name: [Agent's Full Name]

Agent Address: [Agent's Address]

Agent Phone: [Agent's Phone Number]

As my health care agent to make health care decisions on my behalf in the event that I am unable to make such decisions myself.

General Statement of Authority Granted

My agent shall have full authority to make decisions regarding my medical care, including but not limited to:

- Receiving and reviewing my medical records
- Consenting to or refusing treatment
- Making decisions regarding end-of-life care

Effective Date

This durable medical proxy shall become effective when I am determined to be unable to make my own health care decisions by my attending physician.

Revocation of Previous Proxies

This document revokes any prior durable medical proxy or health care directive executed by me.

Signature

_____
[Patient's Full Name]
Date: [Date]

Witness

_____
[Witness Name]
Date: [Date]