Medical Power of Attorney

Principal: [Your Full Name]

Date of Birth: [Your Date of Birth]

Address: [Your Address]

I, [Your Full Name], hereby appoint [Agent's Full Name], residing at [Agent's Address], as my Attorney-in-Fact for medical decisions.

This Power of Attorney shall be effective immediately and shall continue in effect until revoked by me in writing.

Authority Granted

The Attorney-in-Fact shall have full power and authority to make medical decisions on my behalf, including but not limited to:

- Choosing my healthcare providers
- Accessing my medical records
- Making decisions about medical treatments and procedures
- Consenting to or refusing medical interventions

In the event that I become unable to make my own medical decisions, I authorize the Attorney-in-Fact to act in my best interest.

Signatures

Signed this [Date] day of [Month], [Year].

_____

[Your Full Name] (Principal)

_____

[Agent's Full Name] (Agent)

Witnessed by:

_____

[Witness Name]

_____

[Witness Name]