Client Agent Authorization for Healthcare Decisions

Date: [Insert Date]

To Whom It May Concern,

I, [Client's Full Name], born on [Client's Date of Birth], hereby authorize [Agent's Full Name], residing at [Agent's Address], to act as my agent for the purpose of making healthcare decisions on my behalf.

This authorization includes, but is not limited to, the power to:

- Make decisions regarding my medical treatment and care.
- Access my medical records and information.
- Communicate with healthcare providers regarding my health status.

This authorization is effective immediately and will remain in effect until revoked by me in writing.

Sincerely,

[Client's Full Name]
[Client's Address]
[Client's Phone Number]

Signature: ____________________