Durable Power of Attorney for Health Care Decisions

Date: _____

I, **[Your Full Name]**, residing at **[Your Address]**, hereby appoint **[Agent's Full Name]**, residing at **[Agent's Address]**, as my attorney-in-fact for health care decisions.

This Durable Power of Attorney for Health Care Decisions allows my agent to make decisions regarding my medical treatment and care when I am unable to do so.

Limitations on the Authority Granted

My agent shall have the authority to make decisions about my health care, including but not limited to:

- Medical procedures and treatments
- Choosing health care providers
- Accessing my medical records

Effective Date

This document shall become effective immediately unless I specify otherwise here: _____.

Revocation

This Durable Power of Attorney may be revoked by me at any time, but such revocation must be in writing.

In witness whereof, I have hereunto signed my name this ____ day of _____, 20__.

_____
[Your Signature]

_____
[Witness Signature]

_____
[Witness Signature]