Medical Power of Attorney Authorization

Principal's Name: [Your Full Name]

Address: [Your Address]

City, State, ZIP: [City, State, ZIP Code]

Date: [Date]

To Whom It May Concern,

I, [Your Full Name], born on [Your Date of Birth], hereby designate [Agent's Full Name], residing at [Agent's Address], as my attorney-in-fact for healthcare decisions.

This Medical Power of Attorney grants the designated agent the authority to make medical decisions on my behalf if I am unable to do so. This includes, but is not limited to, decisions regarding medical treatment, surgeries, and end-of-life care.

This authorization shall take effect upon my incapacity as determined by a qualified healthcare professional and shall remain in effect until revoked by me in writing.

Please allow this document to serve as my official directive in matters of medical care.

Thank you for your attention to this matter.

Sincerely,

_____
[Your Full Name]
[Your Signature]