Health Care Proxy Appointment Letter

Date: _____

I, _____, residing at _____, do hereby appoint:

Authorized Health Care Proxy

Name: _____

Address: _____

Phone Number: _____

As my health care proxy to make medical decisions on my behalf in the event that I am unable to do so.

Scope of Authority

This appointment grants the proxy authority to make decisions about:

- Medical treatment and procedures
- End-of-life care
- Access to medical records and information

I understand that I have the right to revoke this authorization at any time, in writing.

Signature: _____

Printed Name: _____

Date Signed: _____

Witness Signature: _____

Witness Printed Name: _____

Date: _____