Consent for Medical Decision-Maker Designation

Date: _____

To Whom It May Concern,

I, **[Your Name]**, born on **[Your Date of Birth]**, residing at **[Your Address]**, hereby designate the following person as my Medical Decision-Maker:

Full Name of Designated Decision-Maker: [Designated Person's Name]

Relationship to Me: [Relationship]

Contact Information: [Phone Number and/or Email Address]

This designation grants the above-named individual the authority to make medical decisions on my behalf in the event that I am unable to communicate my wishes due to illness, injury, or incapacitation.

I understand that this designation can be revoked by me at any time, provided I do so in writing.

By signing below, I confirm that I am making this designation voluntarily, and that I have discussed my wishes with my designated decision-maker.

Signature: _____

Print Name: _____

Date: _____

Witness Signature: _____

Print Name: _____

Date: _____

Thank you for your attention to this matter.