

Durable Power of Attorney for Health Care

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

This durable power of attorney is effective immediately and shall remain in effect until revoked by me in writing. My attorney-in-fact shall have the authority to make health care decisions on my behalf, including but not limited to:

- Making decisions about medical treatment and procedures
- Accessing my medical records
- Deciding on end-of-life care

I trust that my attorney-in-fact will act in my best interests and in accordance with my wishes.

In witness whereof, I have executed this Durable Power of Attorney for Health Care on this [Date].

[Your Signature]
[Your Printed Name]

Witnesses:

[Witness 1's Signature]
[Witness 1's Printed Name]

[Witness 2's Signature]
[Witness 2's Printed Name]