Health Care Decision-Making Authority Grant

Date: [Insert Date]

[Your Name]

[Your Address]

[City, State, Zip Code]

To Whom It May Concern,

I, [Your Full Name], hereby grant authority to [Agent's Full Name], residing at [Agent's Address], to make health care decisions on my behalf in the event that I am unable to do so due to health reasons.

This authority includes but is not limited to making decisions regarding medical treatments, procedures, and any other health-related matters that may arise.

This decision-making authority is effective immediately and will remain in effect until revoked by me in writing.

Thank you for your attention to this matter.

Sincerely,

[Your Signature (if sending a hard copy)]

[Your Printed Name]