Medical Decision Authority Delegation

Date: _____

To whom it may concern,

I, [Your Full Name], born on [Your Date of Birth], residing at [Your Address], hereby delegate my medical decision-making authority to:

[Delegate's Full Name]
[Delegate's Relationship to You]
[Delegate's Address]
[Delegate's Phone Number]

This delegation is effective immediately and shall remain in effect until revoked or until [Specify End Date, if any]. I trust that my delegate will make medical decisions on my behalf in accordance with my wishes and best interests.

Thank you for your attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]