

# Authorized Healthcare Proxy Enrollment

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], of [Your Address], hereby designate [Proxy's Name] as my authorized healthcare proxy.

This designation is made voluntarily and reflects my wishes regarding healthcare decisions should I become unable to make such decisions myself.

Proxy's Information:

- Name: [Proxy's Name]
- Address: [Proxy's Address]
- Phone: [Proxy's Phone Number]

My healthcare proxy is authorized to make decisions related to my medical treatment, access my medical records, and communicate with healthcare providers on my behalf.

This authority shall remain in effect until revoked in writing.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Date of Birth]