Health Proxy Assignment Document

Patient Name: [Patient's Full Name]

Date of Birth: [Patient's Date of Birth]

Address: [Patient's Address]

Date: [Current Date]

To Whom It May Concern,

I, [Patient's Full Name], grant authority to [Proxy's Full Name], to serve as my health care proxy. This document authorizes them to make medical decisions on my behalf in the event that I am unable to do so.

Proxy Information:

Name: [Proxy's Full Name]

Relationship: [Relationship to Patient]

Contact Number: [Proxy's Phone Number]

Email Address: [Proxy's Email Address]

This assignment is effective immediately and remains in force until revoked in writing. I affirm that I am of sound mind and understand the implications of this document.

Signature:

_____

[Patient's Full Name]

Witness Signature:

_____

[Witness Full Name]