# Medical Power of Attorney Registration

Date: [Insert Date]

To Whom It May Concern,

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

This Medical Power of Attorney authorizes my agent to make medical decisions on my behalf in the event that I am unable to communicate my wishes due to illness or incapacity.

My agent shall have full power and authority to make all decisions regarding my medical treatment, including but not limited to the authority to:

- Consent to or refuse any medical treatment, procedure, or intervention.
- Access my medical records and obtain information relevant to my treatment.
- Make decisions regarding life-sustaining treatments.

This authorization is effective immediately and will remain in effect until revoked in writing.

Signed,

[Your Signature]

[Your Printed Name]

[Your Date of Birth]

[Your Phone Number]

[Witness Signature (if required)]

[Witness Printed Name]