

Durable Power of Attorney for Healthcare

Date: _____

I, **[Your Name]**, residing at **[Your Address]**, hereby appoint:

[Agent's Name], residing at **[Agent's Address]**,

as my attorney-in-fact for healthcare decisions.

Grant of Authority

I grant my agent full authority to make healthcare decisions on my behalf, including but not limited to:

- Choosing medical providers
- Consenting to or refusing treatment
- Accessing my medical records

Effective Date

This durable power of attorney for healthcare shall become effective immediately and shall remain in effect even if I become incapacitated.

Signature

[Your Name]

Witnesses

This document was signed in my presence by [Your Name].

Signature: _____

Name: _____

Address: _____

Date: _____