Healthcare Proxy Designation

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], residing at [Your Address], hereby designate [Proxy's Full Name] as my healthcare proxy. This individual shall have the authority to make medical decisions on my behalf in the event that I am unable to do so.

Proxy's Information:

- Name: [Proxy's Full Name]
- Relationship: [Relationship to the Proxy]
- Address: [Proxy's Address]
- Phone Number: [Proxy's Phone Number]

This designation is effective immediately and shall remain in effect until revoked in writing by me.

Signature: ______________________________

[Your Full Name]
[Your Date of Birth]
[Your Phone Number]

Witness:

Name: ______________________________

Signature: ___________________________

Date: _______________________________

Thank you.