Healthcare Wishes Documentation

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], born on [Your Date of Birth], residing at [Your Address], hereby express my healthcare wishes and directives in the event that I am unable to communicate my preferences regarding medical treatment.

Healthcare Provider Information

Primary Healthcare Provider: [Provider Name]

Contact Information: [Provider Phone Number and Address]

Healthcare Wishes

In the event that I am unable to make decisions regarding my healthcare, I wish to direct the following:

- Life-Sustaining Treatments: [Specify preferences]
- Pain Management: [Specify preferences]
- Organ Donation: [Specify preferences]
- Other Preferences: [Specify any additional wishes]

Durable Power of Attorney for Healthcare

I designate [Agent's Name] as my healthcare proxy, who will make decisions on my behalf in accordance with my wishes as stated in this document.

Signature

Signature: _____

Date: _____

Witness Signature: _____

Date: _____