Medical Power of Attorney

Principal: [Your Full Name]
Address: [Your Address]
City, State, Zip: [Your City, State, Zip]
Date: [Date]

I, [Your Full Name], hereby appoint [Agent's Full Name] as my healthcare agent to make medical decisions on my behalf if I am unable to do so.

Agent Information

Name: [Agent's Full Name]
Address: [Agent's Address]
Phone Number: [Agent's Phone Number]

Authority Granted

The agent shall have full authority to make medical decisions, including but not limited to:

- Consent to or refuse medical treatment
- Access medical records
- Make decisions regarding life-sustaining treatment

Effectiveness

This Medical Power of Attorney shall become effective upon my incapacity as determined by a qualified physician.

Signature

_____
[Your Full Name]
Principal's Signature

Witnesses

_____
[Witness Name]

_____
[Witness Name]