Power of Attorney for Medical Decisions

Date: [Insert Date]

To Whom It May Concern,

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

This power of attorney shall become effective immediately and shall remain in effect until revoked by me in writing.

My attorney-in-fact shall have the authority to make any medical decisions on my behalf if I am unable to do so due to incapacity. This authority includes, but is not limited to, decisions regarding medical treatments, surgical procedures, and life support measures.

In witness whereof, I have hereunto set my hand this [Insert Day] day of [Insert Month], [Insert Year].

_____
[Your Full Name]

_____
Witness Name
Address: [Witness Address]

_____
Witness Name
Address: [Witness Address]