Designation of Healthcare Agent

Date: ___________________

To Whom It May Concern,

I, **[Your Full Name]**, born on **[Your Date of Birth]**, residing at **[Your Address]**, designate the following individual as my Healthcare Agent:

Healthcare Agent Information

Name: [Agent's Full Name]

Relationship: [Relationship to You]

Address: [Agent's Address]

Phone Number: [Agent's Phone Number]

This designation is made in accordance with my rights under applicable state law. In the event that I am unable to make healthcare decisions for myself, I authorize my Healthcare Agent to make such decisions on my behalf, including but not limited to decisions regarding medical treatment, procedures, and end-of-life care.

This document is intended to take effect immediately unless I revoke it in writing.

Signed,

____
[Your Signature]
[Your Printed Name]

Witnessed by:

____
[Witness Signature]
[Witness Printed Name]

____
[Witness Signature]
[Witness Printed Name]