Durable Power of Attorney for Health Care

Principal: [Your Name]
Address: [Your Address]
City, State, Zip: [City, State, Zip Code]
Phone: [Your Phone Number]
Date: [Date]

I, [Your Name], hereby appoint [Agent's Name], residing at [Agent's Address], as my attorney-in-fact to make health care decisions on my behalf if I am unable to do so.

This Durable Power of Attorney for Health Care is effective upon my incapacity and shall remain in effect until my death or revocation.

My agent shall have the authority to make decisions about my health care, including but not limited to:

- Medical treatments and procedures
- Choice of health care facilities
- End-of-life decisions

I revoke any prior Durable Power of Attorney for Health Care made by me.

Signature of Principal: _____
Date: _____

Witness: _____
Date: _____

Notary Public: _____
Date: _____