Health Care Representative Declaration

Date: **[Insert Date]**

To Whom It May Concern,

I, **[Your Name]**, residing at **[Your Address]**, hereby declare that I appoint **[Representative's Name]**, residing at **[Representative's Address]**, as my Health Care Representative.

This declaration is made to ensure that my health care decisions are made according to my wishes in the event that I am unable to communicate them myself.

My Health Care Representative is authorized to make decisions regarding my medical treatment, including consent for procedures and the right to access my medical records.

Signature: _____

Printed Name: **[Your Name]**

Witnessed by:

Signature: _____

Name: **[Witness Name]**

Date: **[Insert Date]**