

Medical Power of Attorney Assignment

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], residing at [Your Address], do hereby appoint [Agent's Full Name], residing at [Agent's Address], as my Attorney-in-Fact to act on my behalf in all matters pertaining to my medical care and treatment.

This assignment grants my Attorney-in-Fact the authority to make decisions regarding my medical treatment, including but not limited to the following:

- Access to my medical records.
- Making decisions about surgery and other procedures.
- Withholding or withdrawing treatment in accordance with my wishes.

In the event that my Agent is unable or unwilling to act on my behalf, I appoint [Alternate Agent's Full Name] as my alternate Attorney-in-Fact.

This Medical Power of Attorney shall be effective immediately and will remain in effect until revoked by me in writing.

Signed,

[Your Signature]

[Your Printed Name]

Witnessed by:

[Witness Signature] [Date]

[Witness Printed Name]

Notarization (if required):

State of [State], County of [County]

Subscribed and sworn to before me this [Date].

[Notary Signature] [Notary Seal]