Proxy Authorization for Medical Decisions

To Whom It May Concern,

I, [Your Full Name], residing at [Your Address], hereby designate and appoint:

[Proxy's Full Name]
Address: [Proxy's Address]
Relationship: [Your Relationship to Proxy]

as my authorized representative (the "Proxy") for making medical decisions on my behalf in the event that I am unable to do so due to incapacitation or any other reason.

This proxy authorization grants the Proxy the authority to make decisions regarding my medical treatment, healthcare procedures, and access my medical records. This authority will remain in effect until I revoke it in writing.

Additionally, I confirm that this authorization is made voluntarily and without any coercion from any party.

Signed this [Date] day of [Month, Year].

_____
[Your Full Name]
[Your Signature]

Witnessed by:

_____
[Witness Full Name]
[Witness Signature]
Date: [Date]