

Legal Representative Authorization for Medical Decisions

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], born on [Your Date of Birth], residing at [Your Address], hereby appoint [Representative's Full Name], born on [Representative's Date of Birth], residing at [Representative's Address], as my legal representative for medical decisions.

This authorization grants [Representative's Full Name] the authority to make medical decisions on my behalf in the event that I am unable to do so due to illness, injury, or incapacity.

This authorization will remain in effect until revoked in writing by me.

Thank you for your attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Contact Information]