Medical Power of Attorney Authorization

To Whom It May Concern,

I, [Your Full Name], born on [Your Date of Birth], residing at [Your Address], hereby appoint [Agent's Full Name], residing at [Agent's Address], as my attorney-in-fact for medical purposes.

This authorization grants my agent the power to make medical decisions on my behalf if I am unable to do so due to illness or incapacity. This includes, but is not limited to, decisions regarding medical treatments, procedures, and healthcare facilities.

I understand that this authorization is effective immediately and will remain in effect until revoked by me in writing.

Signed,

[Your Signature]

[Date]

Contact Information

Agent's Phone: [Agent's Phone Number]

Agent's Email: [Agent's Email]

Witness

Witness Signature: __________________________

Witness Name: [Witness Full Name]

Date: [Date]