

# Medical Proxy Authorization Letter

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], residing at [Your Address], am of sound mind and hereby designate [Proxy Name], residing at [Proxy Address], as my medical proxy to make healthcare decisions on my behalf in the event I am unable to do so.

This authorization includes the power to make decisions regarding medical treatment, surgical procedures, and any other healthcare interventions as deemed necessary by my healthcare providers.

This authorization is effective immediately and shall remain in effect until revoked in writing.

Signed,

[Your Signature]

[Your Printed Name]

[Your Contact Information]

Witnessed by:

[Witness Signature]

[Witness Printed Name]

[Witness Contact Information]