Medical Proxy Authorization Letter

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], born on [Your Date of Birth], residing at [Your Address], hereby appoint my family member, [Family Member's Full Name], born on [Family Member's Date of Birth], residing at [Family Member's Address], as my medical proxy.

This authorization grants [Family Member's Name] the authority to make medical decisions on my behalf in the event that I am unable to do so, including but not limited to the right to access my medical records and to consent to or refuse treatment as deemed necessary by my healthcare providers.

This authorization is effective as of [Start Date] and will remain in effect until [End Date], or until revoked in writing by me.

Signed,

[Your Signature]

[Your Printed Name]

[Your Contact Information]

Witnessed by:

[Witness's Signature]

[Witness's Printed Name]

[Witness's Contact Information]