Medical Proxy Authorization Letter

Date: [Insert Date]

From: [Your Name]
[Your Address]
[City, State, Zip Code]
[Your Phone Number]
[Your Email Address]

To: [Friend's Name]
[Friend's Address]
[City, State, Zip Code]

Dear [Friend's Name],

I, [Your Name], hereby appoint you, [Friend's Name], as my medical proxy. This authorization allows you to make health care decisions on my behalf in the event that I am unable to do so.

This medical proxy authorization includes, but is not limited to:

- Decisions regarding medical treatments
- Access to my medical records
- Consultation with healthcare providers on my behalf

This authorization is valid until revoked in writing. If I am of sound mind, I reserve the right to revoke this authorization at any time.

Please indicate your acceptance of this medical proxy authorization by signing below.

Sincerely,

[Your Signature]
[Your Printed Name]

Accepted by:
[Friend's Signature]
[Friend's Printed Name]