

Medical Proxy Authorization Letter

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], residing at [Your Address], hereby designate my long-term partner, [Partner's Full Name], residing at [Partner's Address], as my medical proxy.

This authorization grants my partner the authority to make medical decisions on my behalf in the event that I am unable to do so due to illness or incapacitation. This includes decisions regarding medical treatments, procedures, and any other healthcare-related matters.

I acknowledge that this authorization is effective immediately and will remain in effect until revoked by me in writing. I have discussed my healthcare preferences with my partner, and I trust them to make decisions that align with my values and wishes.

Thank you for your understanding in this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Phone Number]