Medical Proxy Authorization

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], born on [Your Date of Birth], residing at [Your Address], hereby designate [Proxy's Name], residing at [Proxy's Address], as my medical proxy.

Authority Granted

This authorization grants my proxy the authority to make medical decisions on my behalf in the event that I am unable to do so.

Specific Medical Instructions

It is my wish that my medical proxy considers the following instructions:

- In the event of a terminal illness, I wish to receive palliative care only, without aggressive treatment.
- If I become incapacitated and cannot communicate, I do not wish to be placed on a ventilator.
- Should I require pain management, I authorize the use of medication, including opioids, as prescribed to ensure comfort.
- I would like my proxy to consult with [Specific Doctor or Specialist's Name] for any medical decisions regarding my treatment.

Duration of Authorization

This authorization is effective until [Insert End Date or State "until revoked"].

Signature: _____

[Your Name]

Witness Signature: _____

[Witness Name]