Estate Planning Authorization for End-of-Life Care Preferences

Date: **[Insert Date]**

To Whom It May Concern,

I, **[Your Name]**, born on **[Your Date of Birth]**, residing at **[Your Address]**, hereby declare my preferences regarding end-of-life care and authorize the individual named below to act on my behalf in making decisions related to my healthcare.

Designated Authority

I designate **[Agent's Name]**, residing at **[Agent's Address]**, as my agent to make healthcare decisions for me in accordance with my wishes should I become unable to communicate these preferences.

Healthcare Preferences

In the event that I am unable to make my own healthcare decisions, I express the following preferences:

- **Life-Sustaining Treatment:** [Specify preferences regarding resuscitation, mechanical ventilation, etc.]
- **Pain Management:** [Specify preferences related to palliative care and pain relief.]
- **Organ Donation:** [State your wishes regarding organ donation.]

Additional Instructions

[Any additional instructions or preferences can be included here.]

This authorization shall remain in effect until revoked in writing. I understand that this document is binding to the extent permitted by law.

Signed,

____

[Your Name]
[Your Signature]
[Date of Signature]

Witnessed by:

[Witness Name]
[Witness Signature]
[Date of Signature]