Healthcare Decisions Authorization Letter

Date: _____

To Whom It May Concern,

I, **[Your Full Name]**, born on **[Your Date of Birth]**, currently residing at **[Your Address]**, hereby designate **[Agent's Full Name]**, residing at **[Agent's Address]**, as my authorized representative to make healthcare decisions on my behalf in the event that I am unable to make those decisions myself.

This authorization includes the power to make decisions related to my medical treatment, access my medical records, and communicate with healthcare providers as necessary for my care.

This authorization is effective immediately and will remain in effect until revoked by me in writing.

Signed,

_____
[Your Full Name]
[Your Signature]

Witness:

_____
[Witness Full Name]
[Witness Signature]