Domestic Partner Consent for Medical Decisions

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], residing at [Your Address], hereby declare that I am in a domestic partnership with [Partner's Name], residing at [Partner's Address].

I authorize my domestic partner, [Partner's Name], to make medical decisions on my behalf in the event that I am unable to do so due to illness or incapacity.

This consent includes but is not limited to decisions regarding medical treatment, surgery, and end-of-life care.

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

Thank you for your attention to this matter.

Sincerely,

[Your Signature]

[Your Printed Name]

[Your Contact Information]