Medical Power of Attorney Consent

I, the undersigned, designate the following person as my agent to make healthcare decisions on my behalf in the event that I become unable to do so.

Principal Information

Full Name

Address

Phone Number

Agent (Attorney-in-Fact) Information

Full Name

Address

Phone Number

Special Instructions

By signing below, I acknowledge that I understand the nature of this document and authorize my agent to make medical decisions in accordance with my wishes.

Principal's Signature

Date

Agent's Signature

Date