

# MEDICAL POWER OF ATTORNEY IMPORTANT NOTICE

Please review the following information carefully before signing this document. Seek guidance from a healthcare professional or attorney if you have any questions or concerns about the terms.

By signing this document, you are authorizing the person you designate as your agent to make medical decisions on your behalf. This includes decisions regarding medical treatments, procedures, diagnoses, and the treatment of both mental and physical conditions. Your agent will have the authority to make decisions just as you would if you were able, including consenting to, refusing, or withdrawing life-sustaining treatment. Therefore, it is crucial to choose someone you trust and who understands your healthcare preferences.

You retain the right to make your healthcare decisions as long as you are mentally competent. Your agent will only act on your behalf if your physician determines that you are no longer able to make medical decisions.

Your chosen agent must be at least eighteen years old and someone you trust with your healthcare. They will not be held liable for decisions made in good faith. Ensure that your agent is willing to take on this role and discuss your medical preferences with them. You may also appoint a backup agent who is aware of your preferences and over eighteen years old.

You have the right to revoke this document at any time while you are still mentally competent. You can do so by informing your medical provider and agent verbally or in writing. Executing another power of attorney will revoke this one.

This document must be signed in the presence of a notary public or two independent witnesses who are over eighteen and competent. They cannot be your agent or related to your agent.

# MEDICAL POWER OF ATTORNEY

## 1. APPOINTMENT OF HEALTH CARE AGENT

**Principal:** I, [PRINCIPAL'S NAME], residing at [MAILING ADDRESS], hereby appoint:

**Agent:** [AGENT'S NAME], residing at [AGENT'S ADDRESS], as my Agent to make medical decisions on my behalf, subject to any limitations set forth in this document. This power of attorney takes effect immediately upon my signature and upon written certification by my doctor that I am unable to make healthcare decisions.

**Agent Contact Information:**

**Phone:** [PHONE]

**Email:** [E-MAIL ADDRESS]

## 2. LIMITATIONS ON MY AGENT

My agent is authorized to make all medical decisions on my behalf EXCEPT:

[LIST ANY LIMITATIONS]

## 3. APPOINTMENT OF ALTERNATE AGENT

If my primary agent is unable or unwilling to serve, I appoint the following alternate agents, in the order listed, with the authority to make healthcare decisions on my behalf:

**First Alternate Agent:**

**Name:** [1ST ALTERNATE AGENT'S NAME]

**Address:** [1ST ALTERNATE AGENT'S ADDRESS]

**Phone:** [1ST ALTERNATE AGENT'S PHONE]

**Second Alternate Agent:**

**Name:** [2ND ALTERNATE AGENT'S NAME]

**Address:** [2ND ALTERNATE AGENT'S ADDRESS]

**Phone:** [2ND ALTERNATE AGENT'S PHONE]

#### 4. ORIGINAL AND COPIES OF THIS DOCUMENT

The original document is/will be filed at the following location(s):

[List location(s)]

Copies will be provided to:

[List recipients]

#### 5. DURATION

This document remains in effect until revoked. It cannot be revoked while I am considered incompetent to make my own decisions.

- **IN PERPETUITY:** This power of attorney expires upon my death or written revocation.
- **END DATE:** This power of attorney expires on [DATE].

#### 6. PRIOR MEDICAL POWER OF ATTORNEY

By signing this document, I revoke any prior medical powers of attorney I have executed.

#### 7. LEGAL REQUIREMENTS (STATE LAW)

This document must be dated and signed by the principal. You may also have your signature acknowledged before a notary public or sign in the presence of two competent adult witnesses not related by blood or marriage.

#### SIGNATURES

Principal's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTARY ACKNOWLEDGMENT**

**State of:** \_\_\_\_\_ }  
**County of:** \_\_\_\_\_ }

On this \_\_\_\_ day of \_\_\_\_\_, 20, before me, \_\_\_\_\_, appeared as Principal of this Medical Power of Attorney, proving through government-issued photo identification to be the above-named person, executing this document as their free act and deed in my presence.

Notary Public: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
My commission expires: \_\_\_\_\_

**WITNESS STATEMENT AND ACKNOWLEDGMENT:**

I am not the person appointed as agent or successor agent in this medical power of attorney. I am not related to the principal by blood or marriage, entitled to any portion of their estate, or involved in providing direct patient care to them. I am not an officer, director, partner, or business office employee of any healthcare facility.

**1st Witness Signature:** \_\_\_\_\_  
**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Address:** \_\_\_\_\_

**2nd Witness Signature:** \_\_\_\_\_  
**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Address:** \_\_\_\_\_