Medical (Healthcare) Power of Attorney

This Power of Attorney is made on this \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

# 1. Principal

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 2. Attorney-in-Fact

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 3. Powers Granted

The Attorney-in-Fact is granted authority to make healthcare decisions for the Principal, including medical treatment choices, hospital admissions, and consent to or refusal of procedures, should the Principal become unable to make such decisions.

# 4. Effective Date and Duration

This Power of Attorney shall become effective on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and shall remain in effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or until revoked by the Principal in writing.

# 5. Governing Law

This Power of Attorney shall be governed by the laws of the state of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

# 6. Signatures

IN WITNESS WHEREOF, the Principal has executed this Power of Attorney on the date set forth above.

Principal Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Attorney-in-Fact Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

# 7. Witnesses / Notary Acknowledgment

Witness 1:
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness 2:
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public:
Subscribed and sworn before me on this \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

Notary Public Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_