MEDICAL POWER OF ATTORNEY

I,	, residing at	, hereby appoint:
Agent's full name:		
Agent's address:		
Agent's contact information: _		
to be my attorney-in-fact for heal	h care decisions.	
I hereby grant my agent the auth limitations or special instructions		healthcare decisions for me, subject to any
		regarding my medical treatment, surgical healthcare matters. This authority includes,
Consenting to, refusing, or wi	thdrawing medical treatme	ent.
Accessing my medical record	s and information.	
Choosing health care provide	rs and facilities.	
 Making decisions about life hydration. 	-sustaining treatments, ir	ncluding the use of artificial nutrition and
I have the following special instru	ctions or limitations regard	ding the authority granted to my agent:
Insurance Portability and Account to make informed healthcare dec This Medical Power of Attorney	tability Act (HIPAA) and apsisions on my behalf. s effective as of	formation (PHI) as required by the Health pplicable state laws, to the extent necessary , and it shall remain in effect
3 , 1	•	of attorney, or unless otherwise specified. Bey at any time by notifying my agent and all
relevant health care providers in		ey at any time by notifying my agent and an
This Medical Power of Attorney s	hall be governed by and co	onstrued in accordance with the laws of
		orney on this day,
Printed name and signature:		Date: