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 health care decisions.

I hereby grant my agent the authority to make any and all healthcare decisions for me, subject to any limitations or special instructions I may specify below.

My agent shall have the power to make decisions regarding my medical treatment, surgical procedures, medications, medical interventions, and other healthcare matters. This authority includes, but is not limited to:

- Consenting to, refusing, or withdrawing medical treatment.
- Accessing my medical records and information.
- Choosing health care providers and facilities.
- Making decisions about life-sustaining treatments, including the use of artificial nutrition and hydration.

I have the following special instructions or limitations regarding the authority granted to my agent:

I authorize my agent to receive my protected health information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws, to the extent necessary to make informed healthcare decisions on my behalf.

This Medical Power of Attorney is effective as of _____, and it shall remain in effect unless I revoke it in writing, provide a new medical power of attorney, or unless otherwise specified.

I reserve the right to revoke this Medical Power of Attorney at any time by notifying my agent and all relevant health care providers in writing.

This Medical Power of Attorney shall be governed by and construed in accordance with the laws of

_____.

In witness whereof, I have signed this Medical Power of Attorney on this day, _____.

Printed name and signature: _____ **Date:** _____