MEDICAL POWER OF ATTORNEY

Free fillable PDF • Health-care agent • General nationwide draft

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1. PRINCIPAL

I appoint the health-care agent named below to make medical decisions for me if I cannot make them myself.

Full legal name

Street address

City / State / ZIP

Date of birth

Phone

Email

2. HEALTH-CARE AGENT

Agent full legal name

Relationship to me

Address

Phone

Email

3. ALTERNATE HEALTH-CARE AGENT (OPTIONAL)

Alternate agent full legal name

Phone

Relationship

4. AUTHORITY

Unless I limit this paper, my agent may accept, refuse, or stop medical treatment for me, choose providers and facilities, see my medical records, and talk with my doctors. This includes the authority needed under HIPAA to receive my protected health information.

☐ Full health-care authority, including records access

☐ Limited authority, as I write below

Limits or special instructions (optional)

5. LIVING WILL

If I have a living will or other advance directive, my agent should follow it unless a court or my state's law says otherwise.

☐ I have a living will or advance directive

☐ I do not have one yet

6. SIGNATURE OF PRINCIPAL

Date

State where signed

Principal signature

Printed name

7. WITNESSES

Many states require witnesses who are not the agent, not a treating provider, and not an heir.
Follow your state's rules.

Witness 1 signature

Printed name

Date

Witness 2 signature

Printed name

Date

8. NOTARY

State of

County of

Notary signature and commission expiration