# Medical Power of Attorney Form

*This legal document authorizes a designated individual to make healthcare decisions on behalf of another person (the "Principal") in the event that the Principal becomes unable to make such decisions.*

## Principal Information

**Full Name:** {principalName}

**Date of Birth:** {principalDOB}

**Address:** {principalAddress}

**Phone Number:** {principalPhone}

## Designated Healthcare Agent

**Full Name:** {agentName}

**Relationship to Principal:** {agentRelationship}

**Address:** {agentAddress}

**Phone Number:** {agentPhone}

## Alternate Agent

{#hasAlternateAgent}

**Full Name:** {alternateAgentName}

**Relationship to Principal:** {alternateAgentRelationship}

**Address:** {alternateAgentAddress}

**Phone Number:** {alternateAgentPhone}

{/hasAlternateAgent}

## Authority Granted

The healthcare agent designated in this form is authorized to make medical and healthcare decisions on behalf of the principal when the principal is incapable of making or communicating such decisions. The authority includes but is not limited to:

{#authorities}

* {authorityItem}

{/authorities}

## Limitations or Special Instructions

*If you have specific limitations or special instructions for your agent, please describe them below:*

{specialInstructions}

## Signatures

**Principal’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** {signatureDate}

## Witnesses

The following individuals witnessed the Principal signing this Medical Power of Attorney.

|  |  |  |
| --- | --- | --- |
| **Witness Name** | **Address** | **Signature** |
| {#witnesses}{witnessName} | {witnessAddress} | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_{/witnesses} |

## Notary Public

*State of {state}*

*County of {county}*

Subscribed and sworn to before me on this {notaryDate} by {principalName}.

**Notary Public Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My Commission Expires:** {commissionExpiration}