

*[Your Name]*

*[Your Address] [City, State ZIP Code]*

*[Date]*

*[Doctor's Name]*

*[Doctor's Address] [City, State ZIP Code]*

Dear Dr. [Doctor's Name],

I, [Your Name], am writing this letter to authorize [Name of Authorized Person] to make medical decisions on my behalf. I understand that I may not be able to make medical decisions for myself at some point in the future, and I want to ensure that someone I trust is able to make decisions for me.

I authorize [Name of Authorized Person] to discuss my medical conditions, treatment options, and medical records with you. I also authorize [Name of Authorized Person] to make decisions regarding my medical treatment, including decisions about medications, surgeries, and other medical procedures.

I understand that this authorization will remain in effect until I revoke it in writing or until [Name of Authorized Person] is no longer able to act on my behalf.

Thank you for your understanding and cooperation in this matter.

Sincerely,

*[Your Signature]*

*[Your Name]*