Medical Power of Attorney Texas Form

PATIENT INFORMATION

Full Name: _____ **Date of Birth:** _____ dd / mm / yyyy

Address: _____ **Phone Number:** _____

AGENT INFORMATION

Full Name: _____ **Address:** _____

Phone Number: _____

Appointment of Agent: I, [Patient's Full Name] _____ , hereby appoint [Agent's Full Name] as my agent for medical decision-making. I grant my agent the authority to make healthcare decisions on my behalf, according to my wishes and values.

Medical Decision-Making Authority: My agent is authorized to make medical decisions, including but not limited to treatments, surgeries, medications, and end-of-life care. This authority includes the ability to consent to, refuse, or withdraw medical interventions.

Special Instructions

Effective Date: _____ dd / mm / yyyy

This Medical Power of Attorney becomes effective on [Effective Date] and remains in effect unless revoked or a different date is specified.

Date: _____ dd / mm / yyyy

Patient's Signature

NOTARIZATION/WITNESSES

This document is signed by the following witnesses or notary public.

Witness/Notary Signature