

# Medical Power of Attorney Texas Form

## Patient Information:

- Full Name:
- Date of Birth:
- 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 and Duration:

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

## Signature:

In witness whereof, I have signed this Medical Power of Attorney Texas Form on [Date] \_\_\_\_\_.

Patient's Signature: \_\_\_\_\_

## Notarization/Witnesses:

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

Signature: \_\_\_\_\_