Virginia Medical Power of Attorney Form

Patient Information:

- **Full Name of Patient:** George Wilson
- **Date of Birth:** January 1, 1970
- **Address:** 123 Main Street
- **City, State, ZIP:** Richmond, VA 23220
- **Phone Number:** (555) 555-5555

Agent Information:

- **Full Name of Agent:** Christian Martin
- **Relationship to Patient:** Attorney
- **Address:** 456 Oak Avenue
- **City, State, ZIP:** Richmond, VA 23221
- **Phone Number:** (555) 555-1234

Appointment of Healthcare Agent

I, the undersigned patient, hereby appoint the above-named agent as my attorney-in-fact to make healthcare decisions on my behalf in the event that I am unable to make or communicate such decisions.

Powers Granted to Agent

I grant my agent the authority to:

- Make decisions regarding medical treatment, including the administration of medication and medical procedures.
- Access and review my medical records and communicate with healthcare providers.
- Make decisions related to mental health treatment if necessary.

Limitations and Special Instructions

I specify the following limitations or special instructions regarding my healthcare:

1. Limitation on End-of-Life Care: I do not wish to receive life-sustaining treatment if I am in a terminal condition with no hope of recovery.
2. Preference for Natural Remedies: I prefer to explore alternative and holistic treatments before consenting to invasive medical procedures.
3. Religious or Cultural Considerations: Please ensure that any medical decisions align with my religious beliefs as a practicing Mormon.
4. Consultation Requirement: Before any major medical decisions are made, I request that my agent consult with Emma Wilson.
5. Preference for Home Care: If possible, I would prefer to receive medical care and treatment in the comfort of my own home rather than in a hospital or healthcare facility.

Witnesses

I declare that I am of sound mind and signing this document voluntarily. I have signed this Virginia Medical Power of Attorney Form in the presence of the following witnesses, who are not related to me and have no financial interest in my healthcare decisions:

1. **Witness Name:** Emma Wilson **Signature:** _____
   Date: February 2, 2024
2. **Witness Name:** Peter Wilson **Signature:** _____
   Date: February 2, 2024

Effective Date and Duration

This Virginia Medical Power of Attorney Form shall be effective as of the date of signing and will remain in effect unless revoked or amended by me.

Date of Signing: February 2, 2024

Revocation

I reserve the right to revoke or amend this Medical Power of Attorney Form at any time, provided I am of sound mind and can communicate my decisions.

Patient's Signature: George Wilson **Date:** February 2, 2024