

Virginia Medical Power of Attorney Form

Patient Information:

- Full Name of Patient: _____
- Date of Birth: _____
- Address: _____
- City, State, ZIP: _____
- Phone Number: _____

Agent Information:

- Full Name of Agent: _____
- Relationship to Patient: _____
- Address: _____
- City, State, ZIP: _____
- Phone Number: _____

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:

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-
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Limitations and Special Instructions

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

1. _____
 2. _____
 3. _____
 4. _____
 5. _____
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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:** _____ **Signature:** _____
Date: _____
 2. **Witness Name:** _____ **Signature:** _____
Date: _____
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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: _____

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: _____ **Date:** _____