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| |  | | --- | |  | | **Authority Letter**  Power of Attorney | |  | | To  [Receiver Name]  [Receiver Title]  [Addess]  [Email] | |  | | From  [Sender Name]  [Sender Title]  [Addess]  [Email] | | |  | | --- | | **Subject:** Medical Power of Attorney Authorization Letter  Dear Dr. Johnson,  I, [Your Name], residing at [Your Address], hereby grant [Agent Name], residing at [Agent Address], the authority to act as my Agent for medical consent purposes. This letter is intended to ensure that my medical decisions are promptly made and communicated in situations where I am unable to do so myself.  I understand and acknowledge that my Agent is authorized to make medical decisions on my behalf only when I am incapable of making such decisions or communicating them due to physical or mental incapacity. This authorization is limited to medical treatment and healthcare-related matters and does not grant my Agent the authority to handle any other aspects of my personal, financial, or legal affairs.  I trust my Agent to make informed and thoughtful decisions in line with my best interests and personal values. I hereby grant my Agent the following specific powers:   * To access my medical records and information, including diagnoses, treatment plans, and test results. * To make decisions regarding medical treatments, procedures, surgeries, medications, and other healthcare-related interventions. * To consent to or refuse medical treatments, procedures, or interventions on my behalf. * To communicate with healthcare professionals, doctors, nurses, and other medical personnel about my condition and treatment options. * To make decisions about my healthcare facility or hospitalization, including admission, discharge, and transfers.   This authorization is effective immediately and shall remain in effect until I provide a written revocation or until December 31, 20XX. I reserve the right to revoke this Medical Power of Attorney Authorization Letter at any time by providing written notice to my Agent and all relevant healthcare providers.  Please be aware that this authorization may be presented to healthcare facilities and professionals to facilitate the necessary medical care and treatment. I kindly request your prompt and cooperative response to my Agent's requests for information and decision-making, as it is my intention to ensure seamless and timely medical attention when needed.  Thank you for your understanding and cooperation. Should you have any questions or require additional information, please do not hesitate to contact me at [Contact Number] or [Email Address].  Sincerely,  Sarah Thompson  Witness: Alexandra Miller  789 Pine Street,  Springfield, IL 12345 | |