

GENERIC MEDICAL POWER OF ATTORNEY TEMPLATE

For adaptation to state-specific medical power of attorney, health care proxy, or durable power of attorney for health care forms

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IMPORTANT EDUCATIONAL USE NOTICE

This template is for general educational and organizational purposes only. It is not legal advice, does not create an attorney-client relationship, and may not be valid or accepted by a hospital, clinic, long-term care facility, court, or state agency without state-specific revisions. Medical power of attorney laws, advance directive terminology, required statutory language, execution rules, witness restrictions, notarization rules, HIPAA authorization rules, mental-capacity standards, pregnancy provisions, revocation rules, and emergency medical order rules vary by state and circumstance. Consult a licensed attorney, your local court or state health agency, a hospital patient advocate, or a qualified advance-care-planning resource before signing anything that affects health care decisions, privacy rights, end-of-life care, safety, or legal status.

How to Use This Template

- Replace every bracketed placeholder with accurate, person-specific information.
- Confirm whether your state uses the term Medical Power of Attorney, Health Care Proxy, Health Care Power of Attorney, Durable Power of Attorney for Health Care, Patient Advocate Designation, or Advance Health Care Directive.
- Compare this document with your state statutory form before signing. Many states publish preferred or mandatory language.
- Decide whether this document should stand alone or be combined with a living will, advance directive, HIPAA authorization, mental health directive, or organ donation instruction.
- Do not sign until you confirm your state witness, notary, and disqualified-witness rules.
- Give copies to your agent, alternate agents, primary physician, hospital, long-term care facility, and trusted family members where appropriate.
- Keep the original where it can be found quickly. A locked safe may delay access during an emergency.

State-Specific Items to Verify Before Signing

- Required statutory form, disclosure statement, warnings, or exact language.
- Whether witnesses, notarization, or both are required.
- Who may not serve as a witness, such as an agent, alternate agent, treating health care provider, facility employee, spouse, relative, heir, or beneficiary.
- Whether the document becomes effective only after incapacity or may be effective immediately for consultation and records access.
- Whether special language is required for mental health treatment, facility admission, artificial nutrition and hydration, pregnancy, organ donation, or anatomical gifts.
- Whether a separate HIPAA authorization is required or recommended.
- Whether a separate DNR, POLST, MOLST, POST, or physician order is required for emergency responders.
- Rules for revoking prior health care powers of attorney or advance directives.
- Whether your state requires a copy to be placed in a registry, medical record, or patient portal.
- Whether military service, tribal law, immigration status, guardianship, or out-of-state residence creates special issues.

Medical Emergency and Safety Note

This generic form is not designed to handle immediate emergencies by itself.

- If there is an immediate medical emergency, call emergency services.
- If there is abuse, coercion, exploitation, domestic violence, elder abuse, or unsafe disclosure of medical information, consult a licensed attorney, adult protective services, domestic violence advocate, or appropriate emergency resource.
- If you do not want a specific person to receive medical information or participate in decisions, state that clearly and verify whether your state requires additional language.
- If family members may disagree, consider discussing your wishes in advance and obtaining state-specific legal advice before signing.

MEDICAL POWER OF ATTORNEY / HEALTH CARE PROXY

Generic template. Use the terminology and statutory language required in your state.

Use this template only after confirming your state requirements. Delete provisions that do not apply. Add state-specific statutory language if required by your jurisdiction.

1. Principal Information

I, [PRINCIPAL FULL LEGAL NAME], also known as [OTHER NAMES, IF ANY], residing at [ADDRESS OR CONFIDENTIAL ADDRESS METHOD], designate the person or persons below to make health care decisions for me if I am unable to make or communicate those decisions, or at another time permitted by applicable law.

Principal full legal name: _____

Date of birth: _____

Phone number: _____

Email address: _____

Address or confidential address method: _____

2. Appointment of Health Care Agent

I appoint the following person as my health care agent, proxy, surrogate, patient advocate, or representative, using the title recognized by applicable state law:

Agent Information	Details
Full legal name	[AGENT FULL LEGAL NAME]
Relationship to principal	[RELATIONSHIP]
Phone number	[PHONE]
Email address	[EMAIL]
Mailing address	[ADDRESS]

3. Alternate Agents

If my first-choice agent is unavailable, unwilling, disqualified, incapacitated, or cannot be contacted within a reasonable time, I appoint the following alternate agents in the order listed:

Priority	Alternate Agent	Contact Information
First alternate	[FULL LEGAL NAME AND RELATIONSHIP]	[PHONE, EMAIL, ADDRESS]
Second alternate	[FULL LEGAL NAME AND RELATIONSHIP]	[PHONE, EMAIL, ADDRESS]
Additional alternate	[FULL LEGAL NAME AND RELATIONSHIP]	[PHONE, EMAIL, ADDRESS]

Unless applicable law allows co-agents and I expressly state otherwise, only one agent should act at a time. If co-agents are permitted and desired, describe the decision rule here: [UNANIMOUS / MAJORITY / EITHER MAY ACT / OTHER].

4. When My Agent May Act

Choose and revise one option. State law may control when this authority becomes effective.

- My agent may make health care decisions for me only when my attending physician, treating clinician, or other legally authorized professional determines that I lack capacity to make or communicate the relevant decision.
- My agent may receive medical information and participate in discussions immediately, but may make final health care decisions only when I lack capacity, unless state law permits otherwise.
- If permitted by state law, my agent may act immediately regarding the following limited matters: [DESCRIBE LIMITED AUTHORITY].

5. General Grant of Health Care Authority

Subject to my instructions, limitations, and applicable law, my agent may make health care decisions for me, including decisions to request, consent to, refuse, withhold, or withdraw health care, treatment, procedures, medication, testing, surgery, hospitalization, facility placement, hospice, palliative care, pain management, rehabilitation, home health care, and long-term care.

My agent should make decisions according to my known wishes, values, religious or moral beliefs, prior statements, and best interests. My agent should consult with my physicians, clinicians, family members, and trusted advisors when appropriate, but the decision-making authority belongs to the agent to the extent allowed by law.

6. Specific Powers to Confirm or Limit

Some states require specific initials or special language for certain powers. Select only powers permitted and intended.

- Consent to, refuse, withhold, or withdraw life-sustaining treatment as permitted by law.
- Make decisions about artificial nutrition and hydration as permitted by law.
- Make decisions about CPR, ventilation, dialysis, antibiotics, blood products, surgery, testing, and medications as permitted by law.
- Authorize hospice care, palliative care, comfort care, and pain relief, even if pain relief may have secondary effects.
- Admit me to, transfer me from, or discharge me from a hospital, nursing facility, assisted living facility, hospice facility, rehabilitation facility, or other health care setting as permitted by law.
- Make mental health treatment decisions only if permitted by law and only to the following extent: [DESCRIBE].
- Select, discharge, or change physicians, clinicians, hospitals, care facilities, home health providers, and other health care providers.
- Arrange for home care, medical equipment, transportation, medication management, and care coordination.

- Access, obtain, review, and disclose medical records and protected health information as described in the HIPAA section below.
- Apply for public or private health care benefits, insurance coverage, hospice benefits, or facility admission when related to health care decision-making.

7. Limitations on My Agent

My agent may not act contrary to the following instructions, unless emergency circumstances or applicable law require otherwise:

- My agent may not consent to the following treatments or placements: [DESCRIBE].
- My agent may not disclose medical information to the following people except as required by law: [DESCRIBE].
- My agent must consult the following person or group before major decisions, if reasonably possible: [DESCRIBE].
- My agent must follow the following religious, ethical, cultural, or personal values: [DESCRIBE].
- Other limitations: [DESCRIBE].

8. Statement of Health Care Wishes

This section helps guide the agent. It may not replace a state-specific living will or advance directive. Use state-required language if needed.

- If I have a terminal condition and treatment would only prolong the dying process, I want the following: [COMFORT CARE / LIFE-SUSTAINING TREATMENT / OTHER].
- If I am permanently unconscious or in an irreversible condition, I want the following: [COMFORT CARE / LIFE-SUSTAINING TREATMENT / OTHER].
- Regarding CPR, I want the following: [ATTEMPT CPR / DO NOT ATTEMPT CPR ONLY IF A VALID DNR OR PHYSICIAN ORDER EXISTS / DISCUSS WITH PHYSICIAN / OTHER].
- Regarding mechanical ventilation, I want the following: [DESCRIBE].
- Regarding artificial nutrition and hydration, I want the following: [DESCRIBE].
- Regarding dialysis, antibiotics, blood transfusions, surgery, and other major interventions, I want the following: [DESCRIBE].
- Regarding pain relief, comfort care, hospice, spiritual care, and presence of loved ones, I want the following: [DESCRIBE].
- Regarding pregnancy-related provisions, if applicable, I want the following, subject to state law: [DESCRIBE OR DELETE].

9. HIPAA and Medical Records Authorization

To the extent permitted by federal and state privacy law, I authorize my agent and alternate agents to request, receive, inspect, copy, use, and disclose my protected health information, medical records, billing records, mental health records where permitted, substance-use-disorder records where permitted, medication lists, diagnostic results, care plans, and other health information necessary to make or assist with health care decisions for me.

This authorization is intended to be a HIPAA-compliant release to the extent permitted by law. If my state, health care provider, insurer, or facility requires a separate HIPAA authorization, I direct that such form be completed and honored consistent with this document.

10. Organ, Tissue, Eye Donation, Autopsy, and Final Disposition

These matters are often governed by separate state forms or donor registries. Complete only if permitted by law and consistent with other documents.

- I have already registered as an organ, tissue, or eye donor: [YES / NO / UNKNOWN].
- I authorize donation for transplant, therapy, research, or education as follows: [DESCRIBE].
- I do not authorize anatomical gifts: [DESCRIBE].
- I authorize my agent to make decisions regarding autopsy, disposition of remains, funeral arrangements, cremation, burial, or memorial instructions only to the extent permitted by law: [DESCRIBE].

11. Nomination of Guardian or Conservator, if Needed

If a court ever decides that a guardian, conservator, or similar fiduciary is needed for health care or personal decisions, I nominate my health care agent, or the first available alternate agent, to serve in that role to the extent permitted by law. I do not want the following person or persons appointed: [DESCRIBE, IF ANY].

12. Agent Duties and Decision-Making Standard

My agent must act in good faith, within the authority granted, and according to my known wishes. If my wishes are unknown, my agent should act according to my values and best interests. My agent should consider medical facts, prognosis, benefits and burdens of treatment, comfort, dignity, religious or moral beliefs, family impact, and any written or spoken instructions I have provided.

13. Reliance, Copies, and Out-of-State Use

A copy, scan, fax, electronic image, or patient-portal copy of this document should be treated as valid to the fullest extent permitted by law. Health care providers, insurers, facilities, and others may rely on this document unless they have actual knowledge that it has been revoked or replaced. Because state recognition rules vary, I understand that I should consider signing the statutory form for any state where I live, spend significant time, or receive regular medical care.

14. Revocation of Prior Medical Powers of Attorney

To the extent permitted by law, I revoke prior medical powers of attorney, health care proxy appointments, or patient advocate designations that conflict with this document. I do not revoke the following documents unless expressly stated: [LIST ANY LIVING WILL, DNR, POLST, MOLST, POST, ORGAN DONATION REGISTRY, MENTAL HEALTH DIRECTIVE, OR OTHER ADVANCE DIRECTIVE].

I understand that revocation rules vary by state. I should notify my agent, alternate agents, physicians, hospitals, facilities, and family members if I revoke or replace this document.

15. Principal Signature

I sign this document voluntarily. I understand its general purpose. I am not signing because of fraud, duress, coercion, or undue influence. I understand that state-specific law controls the validity and effect of this document.

Principal signature: _____

Printed name: _____

Date: _____

City, county, and state of signing: _____

16. Witness Statement

Use only if witnesses are required or permitted by your state. Witness eligibility rules vary. Some states disqualify agents, relatives, heirs, beneficiaries, treating providers, facility employees, or people financially responsible for care.

Each witness states that the principal appeared to sign voluntarily, appeared to be of sound mind to the extent observable, and was not known to be under fraud, duress, coercion, or undue influence. Each witness also states that the witness is qualified under applicable state law.

Witness	Signature and Printed Name	Address and Date
Witness 1	Signature: _____ Printed name: _____	Address: _____ Date: _____
Witness 2	Signature: _____ Printed name: _____	Address: _____ Date: _____

17. Optional Notary Acknowledgment

Use the notary language required in your state. Some states require notarization, some require witnesses, some allow either, and some impose special rules.

State of _____

County of _____

This document was acknowledged before me on this ____ day of _____, 20____, by [PRINCIPAL FULL LEGAL NAME], who is personally known to me or produced satisfactory identification.

Notary Public signature: _____

Printed name: _____

My commission expires: _____

Notary seal, if required: _____

18. Optional Agent Acceptance

Some states require or recommend an agent acceptance. Even when not required, it may help the agent understand the role.

I, [AGENT FULL LEGAL NAME], accept appointment as health care agent if and when I am authorized to act. I understand that I must act according to the principal's known wishes, this document, and applicable law.

Agent signature: _____

Printed name: _____

Date: _____

19. Optional Alternate Agent Acceptance

I, [ALTERNATE AGENT FULL LEGAL NAME], accept appointment as alternate health care agent if and when I am authorized to act.

Alternate agent signature: _____

Printed name: _____

Date: _____

20. Distribution and Storage Notes

- Original stored at: [LOCATION].
- Copy provided to primary health care agent on: [DATE].
- Copy provided to alternate agents on: [DATE].
- Copy provided to primary care physician on: [DATE].
- Copy uploaded to patient portal or hospital record on: [DATE].
- Copy provided to long-term care facility, assisted living facility, hospice, or specialist on: [DATE].
- Family or trusted contacts informed on: [DATE].

Signing Readiness Checklist

This checklist is not a substitute for legal advice or medical advice. It is an organizational tool only.

- I confirmed the correct state form name and state statutory language.
- I confirmed whether witnesses, notarization, or both are required.
- I confirmed that my witnesses are legally qualified and not disqualified.
- I confirmed whether my chosen agent is eligible to serve under state law.

- I discussed my wishes with my agent and alternate agents.
- I reviewed whether I also need a living will, advance directive, HIPAA authorization, mental health directive, DNR, POLST, MOLST, POST, or organ donation form.
- I reviewed whether family conflict, elder abuse, coercion, domestic violence, privacy, or safety concerns require legal advice before signing.
- I confirmed where the signed original and copies will be stored.
- I understand that financial power of attorney and medical power of attorney are different documents.
- I consulted a licensed attorney, state health agency resource, hospital patient advocate, or qualified professional if I was unsure.

Document Preparation Notes

State-specific name of form: _____

State health agency or court website checked: _____

Required witnesses: _____

Required notary language: _____

Required disclosure statement: _____

Separate HIPAA authorization needed: _____

Separate living will or advance directive needed: _____

Separate DNR/POLST/MOLST/POST needed: _____

Safety or confidentiality concerns: _____

Attorney or patient advocate consulted: _____

End of Template

Use templates to get organized. Use lawyers, doctors, and qualified advocates to get advice.