



RESTORATION

HEALTHCARE POWER OF ATTORNEY

I, Your Full Name _____, referred to as the “Principal,”

I. APPOINTMENT OF HEALTHCARE AGENT

I hereby appoint:

Agent’s Full Name: [Agent’s Full Name]

Agent’s Address: [Agent’s Address]

Agent’s Contact Information: [Agent’s Phone Number, Email]

as my Attorney-in-Fact (Agent) to make healthcare decisions on my behalf if I become unable to make or communicate such decisions.

II. POWERS GRANTED

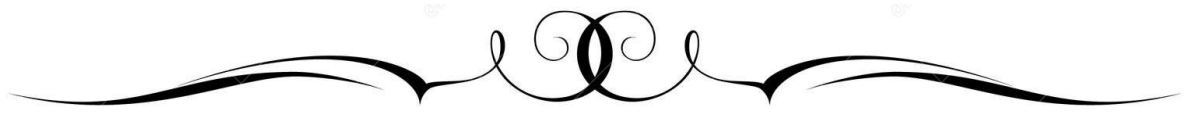
My Agent is authorized to make any and all healthcare decisions on my behalf, including but not limited to:

1. **Medical Treatment:**
 - i. Consent to or refuse any medical treatment, surgery, or procedure.
2. **Choice of Healthcare Providers:**
 - i. Choose healthcare providers, hospitals, or facilities.
3. **Access to Medical Records:**
 - i. Access and release my medical records as necessary.
4. **End-of-Life Decisions:**
 - i. Make decisions regarding life-sustaining treatment and end-of-life care.
5. **Organ and Tissue Donation:**
 - i. Make decisions regarding organ and tissue donation.

IV. Preferences -- Omit if not needed

V. EFFECTIVE DATE

This Healthcare Power of Attorney is effective immediately upon my signing it.



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VII. SIGNATURE

I sign this Healthcare Power of Attorney on [Date].

[Your Full Name (Principal)]

WITNESS:

[Witness Name]

WITNESS:

[Witness Name]