

# SOUTH CAROLINA ADVANCE HEALTHCARE DIRECTIVE

## MEDICAL POWER OF ATTORNEY

### I. Principal

I, \_\_\_\_\_ born on \_\_\_\_\_ residing at \_\_\_\_\_ hereby designate the following individual as my agent to make medical decisions on my behalf:

### II. Agent Information

Agent Name: \_\_\_\_\_

Relationship to Principal: \_\_\_\_\_

Agent Address: \_\_\_\_\_

Agent Phone Number: \_\_\_\_\_

### III. Grant of Authority

I grant my agent the authority to make all medical decisions on my behalf, including but not limited to:

1. Consent to or refuse any medical treatment.
2. Access my medical records.
3. Make decisions about my care, including but not limited to hospitalization, surgery, and other medical procedures.
4. Make end-of-life decisions in accordance with my wishes.

### IV. Effective Date

This Medical Power of Attorney shall become effective immediately and shall remain in effect until revoked by me in writing or until my death.

## V. Revocation of Prior Documents

This document revokes any prior Medical Power of Attorney executed by the Principal.

## VI. Signatures

Principal Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Agent Signature (optional): \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

## VII. Notarization

State of \_\_\_\_\_

County of \_\_\_\_\_

Subscribed, sworn to, and acknowledged before me by \_\_\_\_\_

on this \_\_\_\_\_ day of \_\_\_\_\_,

\_\_\_\_\_.

Notary Public Signature: \_\_\_\_\_

Notary Public Name (Printed): \_\_\_\_\_

My Commission Expires: \_\_\_\_\_