Hospital Visitation Authorization

I, _______________________________________________________________________________,
residing at _____________________________________________________________________ in
_______________________ County, State of ___________________, do hereby give notice and
authorization that if I should become ill or incapacitated through any cause that necessitates
my hospitalization, treatment, or long-term care in a medical facility, it is my wish that the
following person(s) ________________________________________________________________
_________________________________________________________________________ be given
first preference in visiting me in such medical or treatment facility, whether or not there are
parties related to me by blood or law or other parties desiring to visit me, unless or until I
freely give contrary instructions to medical personnel on the premises involved.

Executed this __________ Day of __________ (Month), __________ (Year)
at (location of signing) _______________________________

By: ______________________________________ ____________________
Signature            Date

Witness Signatures:

Witness 1      Witness 2
____________________________________ ____________________________________
Signature      Signature
____________________________________ ____________________________________
Address      Address
____________________________________ ____________________________________
Date       Date

This form is provided by Compassion & Choices. For information about choices at the end
of life and case management services for the terminally ill, please contact us or visit our
website: www.compassionandchoices.org

Compassion & Choices
P.O. Box 101810
Denver, Colorado 80250
800-247-7421