Hospital Visitation Authorization (Advance Directive Addendum)

compassion & choices
Care and Choice at the End of Life

This form enables people not traditionally recognized as family members to gain priority visitation rights. Once completed and signed, it should be kept with the advance directive.

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 they are parties related to me by blood or law, 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 *(Please print this document and sign with a pen.)* Date

WITNESS SIGNATURES:

WITNESS 1

_____

Signature *(Please print this document and sign with a pen.)*

_____

Address

_____

Date

WITNESS 2

_____

Signature *(Please print this document and sign with a pen.)*

_____

Address

_____

Date

** Doctors may see whether the therapy quickly reverses my condition. If it does not, I want it discontinued.*

This document is not intended as legal advice. Your state may have specific laws about how this document should be completed. Consult local counsel for advice specific to your situation.