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

____

Signature

____

Address

____

Date

Witness 2

____

Signature

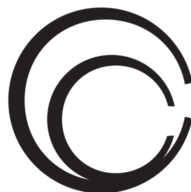
____

Address

____

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



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