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: CompassionAndChoices.org