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 allowed to visit me.

Executed this__________ Day of ________________ , 20_____

at (location of signing) ____

By:____________________________________   ____________________________

Signature   Date

Witness Signatures:

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