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:

_____

_____

And/or, the following person(s) not be allowed to visit me:

_____

_____

Executed this_____ Day of _____ , 20_____

at (location of signing) _____

Signed: _____

Date:_____

Witness Signatures:

Witness 1 Witness 2

_____

_____

Signature Signature

_____

_____

Address Address

_____

_____