

Hospital Visitation Authorization



Compassion & Choices of Oregon
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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), 20__ (Year)

By: _____

Signature

Witness Signatures	Signature	Signature
	Address	Address
	Date	Date