



*cirugía, respecto de nuestro(s) menor(es). Este poder no debe verse afectado por la incapacidad de cualquiera de los dos o de ambos, y continuara en plena vigencia y efecto durante dicha incapacidad.]*

**Revocation:** I (We) retain the right to revoke this Medical Power of Attorney at any time by providing written notice to my (our) Agent.

*[Revocación: Yo (Nosotros) conservo (conservamos) el derecho de revocar este Poder Legal Médico en cualquier momento mediante notificación escrita a mi (nuestro) Agente.]*

**Governing Law:** This Medical Power of Attorney shall be governed by the laws of the State of Maryland.

*[Ley Aplicable: Este Poder Legal Médico se regirá por las leyes del Estado de Maryland.]*

**SIGNATURE AND ACKNOWLEDGEMENT** *(Firma y Reconocimiento)*

Executed this *[Ejecutado este]* \_\_\_\_\_ day of *[día de]* \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_

**STATE OF MARYLAND**  
**COUNTY OF** \_\_\_\_\_

This document was acknowledged before me on \_\_\_\_\_ (date),  
by the parent(s) named above, as principals, to be his/her (their) act.

**(SEAL, IF ANY)**

\_\_\_\_\_  
**Signature of Notary**

**My Commission expires:** \_\_\_\_\_

**WITNESS ATTESTATIONS**

We, the undersigned witnesses, affirm that on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, in the presence of each other, that the parent(s) named above, as principal(s), signed the foregoing Medical Power of Attorney, and declared it to be his/her/their free and voluntary act. We further affirm that we are each at least 18 years of age and that we signed this document as witnesses at the request of the parent(s) named above.

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_