HEALTH CARE POWER OF ATTORNEY & DIRECTIVE

I,_____ as Principal,_____,
(Print Legal Name) (Date of Birth)

make the following Health Care Power of Attorney and Directive, and direct it be honored.

1. Health Care Power of Attorney. I am appointing a health care agent who can decide to accept, refuse or cease medical intervention for my health. I expect my agent to consult with my physician(s) and health care professional(s). I revoke any and all prior health care powers of attorney, and if my general or durable power of attorney includes health care power provisions, then I revoke those provisions and only those provisions. I designate and appoint the person(s) listed below as agent for my health care decisions:

(Print) Name: _____

Address: _____

City/State/Zip: _____

List all Phone numbers: _____

_____

Relationship (Describe): _____

If the above person is unable or unwilling to serve, or can not be found, I designate and appoint the person listed below as an alternate agent for my health care decisions:

(Print) Name: _____

Address: _____

City/State/Zip: _____

List all Phone numbers: _____

_____

Relationship (Describe): _____

2. Effective Date & Durability. This Power of Attorney is effective immediately, will not be affected by my mental incompetence or disability, and terminates upon my death. My agent can make decisions for me in the event that my treating physician determines I have lost the mental capacity to make such decisions for myself, and in addition my agent can make decisions for me in the event I so direct and request.

3. Powers of My Agent. I have explained to my agent that the choices I make now are to be respected. The powers of my agent include, but are not limited to, powers to order the withholding or withdrawal of life-sustaining treatment, and powers to facilitate quality of care

decisions with respect to my life and my beliefs. My agent has the right to execute any documents necessary to carry out their duties. My agent shall have the right to make health care decisions for me, to give informed consent on my behalf regarding my health care, and to withdraw the consent as to any care, treatment, non-treatment, service or procedure to maintain, diagnose or treat a physical condition. My agent shall have the right to receive and review any health information, verbal or recorded in any form or medium, that relates to my past, present, or future physical or mental health or condition, any provision of health care to me, or payment for provisions of such health care, and this right extends six months after my death. This release authority additionally applies to information governed by the Health Insurance Portability and Accountability Act of 1996, as hereafter amended. I waive any patient - physician privilege, and my agent is authorized to re-disclose any information. In addition, my agent's powers include making the following decisions: withhold or cease cardiopulmonary resuscitation (CPR); withhold or withdraw breathing tube (intubation - ventilation); withhold or withdraw intravenous hydration tube; withhold or withdraw nutritional support; withhold or cease dialysis; release me from a hospital or health care facility against medical advice, and authorize the waiving or releasing from liability as required by a hospital or physician; admit me to a nursing home, group home or hospice care; seek comfort measures; and relieve pain.

4. Organ Donation. My agent may donate my organs upon my death.

☐ **YES** ☐ **NO**

5. Body Donation. My agent may donate my body to medical science upon my death.

☐ **YES** ☐ **NO**

6. Reliance. Any person who relies on this document while communicating with my agent is entitled to rely upon the agent's instructions, so long as the person relying on the agent, at the time of any act taken pursuant to this Health Care Power of Attorney, had neither actual nor written notice of revocation or termination. Any action so taken, unless otherwise invalid or unenforceable, shall be binding on my heirs, legatees, or personal representatives.

7. Indemnity. My estate shall hold harmless my agent from all liability for acts or omissions done in good faith.

8. Guardianship. If any guardianship proceeding is initiated under RCW 11.88, I nominate as guardian my first choice of health care agent.

☐ **YES** ☐ **NO**

If my first choice of health care agent is unwilling or unable to act on my behalf, I nominate my alternate agent to serve as guardian.

☐ **YES** ☐ **NO**

9. Health Care Directive. (RCW 70.122) In addition to the above Power of Attorney, I direct any physician to withhold or withdraw life-sustaining treatment and let me die [A] if by written opinion by my attending physician that I have an incurable injury, disease, or illness causing an irreversible terminal condition that will cause death within a reasonable period of

time, and where the application of life-sustaining procedures would serve only to artificially prolong the process of my dying; or [B] if I am diagnosed in writing by two physicians, one of whom is my attending physician and both of whom have personally examined me, to be in a permanent unconscious condition. I revoke any and all prior Health Care Directives.

10. Applicable Law. This document shall be governed by the Laws of the State of Washington. I authorize my health care providers to transfer this original document or any copies of it to any other health care providers or facilities upon their request. Every part shall be fully implemented, and if any part is held invalid the remainder of the document shall be implemented. I know I can add, delete, or change any words and have initialed such changes.

_____ _____

Date Signature

(Print) Principal Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Date of Birth: _____

The undersigned are over the age of eighteen, personally know the Principal, and believe the Principal to be over the age of eighteen and of sound mind capable of making a health care decision. The Principal did not appear to be incapacitated or acting under fraud, undue influence, or duress and was acting voluntarily when signing this document. The witnesses have personally witnessed the Principal sign and date this document on today's date, and we sign this at the request of the Principal and in the Principal's presence.

_____

Date

_____ _____

Witness Signature Witness Signature

_____ _____

Printed Name Printed Name

_____ _____

Address Address

_____ _____

City/State/Zip City/State/Zip

BEGINNING IN 2017, A NOTARY or TWO WITNESSES ARE REQUIRED FOR SIGNING A POWER OF ATTORNEY IN THE STATE OF WASHINGTON

STATE OF _____)
) ss.
COUNTY OF _____)

I certify that _____ personally appeared today before me, to me known to be the individual described and who executed this Health Care Power of Attorney and Directive and acknowledged that this was a free and voluntary act and deed for the uses and purposes mentioned.

_____ _____
Date Notary signature

_____
Notary Name

Residing at _____

Commission expires _____

Notary Seal

SPECIAL NOTICE

Since some other states require a notary for powers of attorneys, the Principal may wish a notarization, which gives greater general acceptance in any event. You can have the notary sign as both a witness on page 3 and then again as a Notary.

Washington law RCW 70.122.030 does require a Health Care Directive to be dated and witnessed by two people. Currently a Power of Attorney requires no verification, but beginning in 2017 it will require either a notary or two witnesses. The witnesses cannot be currently acting as, or be employed by, health care professionals for the Principal; nor be related to the Principal by blood or marriage; nor have any claims or interests against the Principal or the Principal's estate.

Washington law limits the options of who can be a health care agent. Unless they are the spouse, state registered domestic partner, adult child or sibling of the Principal (beginning 2017 parents are included in this group of family members), **the following persons can not be the health care agent for the Principal:**

Any of the Principal's physicians; the physicians' employees; and the owners, administrators, or employees of the health care facility where the Principal resides or receives care.