Name _____

Medical record # _____

# DURABLE POWER OF ATTORNEY FOR HEALTH CARE

**Notice to Person Executing This Document**
**This is an important legal document. Before executing this document you should know these facts:**

- This document gives the person you designate as your Health Care Agent the power to make MOST health care decisions for you and is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions.
- You may include specific limitations in this document on the authority of the Health Care Agent to make health care decisions for you if you choose.
- Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a health care matter, the Health Care Agent GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Health Care Agent to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.
- When exercising his or her authority to make health care decisions for you when deciding on your behalf, the Health Care Agent will have to act consistent with your wishes, or if they are unknown, in your best interest. You may make your wishes known to the Health Care Agent by attaching them to this document or by making them known in another manner.
- When acting under this document the Health Care Agent GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records.

**1. Creation of Durable Power of Attorney for Health Care**

I intend to create a power of attorney (Health Care Agent) by appointing the person or persons designated herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so. This designation becomes effective when I cannot make health care decisions for myself as determined by my attending physician or designee, such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making health care decisions. The Health Care Agent's power shall cease if and when I regain my capacity to make health care decisions. Please see Chapter 11.125 RCW for more information.

**2. Designation of Health Care Agent and Alternate Agents**

If my attending physician or his or her designee determines that I am not capable of giving informed consent to health care, I designate and appoint:

Name _____ Phone _____

Address _____ City, State, ZIP _____

as my attorney-in-fact (Health Care Agent) by granting him or her the Durable Power of Attorney for Health Care and authorize her or him to consult with my physicians about the possibility of my regaining the capacity to make treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.

**Alternate agents**

In the event that the person listed above is unable or unwilling to serve, then I grant these powers to the people listed below as my first and second alternate choices.

1st alternate name _____ Phone _____

Address _____ City, State, ZIP _____

2nd alternate name _____ Phone _____

Address _____ City, State, ZIP _____

Name _____

Medical record # _____

**3. General Statement of Authority Granted**

My Health Care Agent is specifically authorized to give consent for health care treatment when I cannot make my own decisions. My Health Care Agent is authorized to carry out my wishes regarding life-sustaining treatments such as feeding tube, CPR, breathing machine, and kidney dialysis. This includes consent to start, continue, or stop medical treatment. This includes actions such as organ donation and care and disposal of the body after I die, unless otherwise legally specified.

The above authorization to make health care decisions does not include the following absent a court order:

(1) Therapy or other procedure given for the purpose of inducing convulsion;

(2) Surgery solely for the purpose of psychosurgery;

(3) Commitment to or placement in a treatment facility for the mentally ill, except pursuant to the provisions of Chapter 71.05 RCW;

(4) Sterilization.

I hereby revoke any prior grants of durable power of attorney for health care.

**4. Your wishes for medical treatment may be attached to this form should you choose to include them.**

**5. Signatures**

I understand that two witnesses OR a notary must watch me sign this form for it to be legally valid.

- **Option 1—Two witness signatures**

  By my signature below as witness, I attest that: (a) I am not related to the Grantor by blood, marriage, or state registered domestic partnership; (b) I am not the Grantor's health care provider, an employee of the provider, or an employee of an adult family home or long-term care facility where Grantor resides; and (c) I am in the presence of the Grantor and am acting at the Grantor's direction or request.

  DATED this _____day of _____, _____ .
  *(Year)*

  Witness signature:_____

  Witness signature:_____

  GRANTOR (MY SIGNATURE) _____

- **Option 2—Notary**

  STATE OF WASHINGTON ) _____ )ss.

  (COUNTY OF _____)

  I certify that I know or have satisfactory evidence that the GRANTOR, _____ signed this instrument and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in the instrument.

  DATED this _____day of _____, _____ .
  *(Year)*

  _____

  NOTARY PUBLIC in and for the State of Washington,

  residing at _____

  My commission expires _____