Save Document

Print

HEALTH CARE POWER OF ATTORNEY & DIRECTIVE

I, (print legal name) _____ as Principal, make the following Health Care Power of Attorney and Directive, and expect this document to be honored.

1. **Health Care Power of Attorney**. (RCW 11.94) I am appointing a health care agent who can decide to accept, cease or refuse 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 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, and 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 shall include, but not be 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 shall have the right to execute any documents necessary to carry out the duties of the agent. 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. 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, and believe the Principal to be over the age of eighteen and of sound mind, and that the Principal was acting voluntarily and without duress. The witnesses have personally witnessed the Principal sign this document on today's date.

Dated:_____

_____ _____

Witness Signature Witness Signature

_____ _____

Printed Name Printed Name

_____ _____

Address Address

_____ _____

City/State/Zip City/State/Zip

[NOTARY IS OPTIONAL FOR 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_____

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 and then again as a Notary.

Washington law RCW 11.94.010 limits the options of who can be a health care agent. Unless they are the spouse, or adult child or brother or sister of the Principal, **the following persons cannot be the health care agent for the Principal:**

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

Washington law RCW 70.122.030 does require a Health Care Directive to be dated and witnessed by two people. 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 in the Principal's estate.