THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself.

Because "health care" means any treatment, service, or procedures to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's

assistance to complete this document, but **if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.**

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy.

You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

Unless he or she is your spouse, or adult child or brother or sister, none of the following persons may act as your attorney-in-fact: your physicians, the physicians' employees, or the owners, administrators, or employees of the health care facility where you reside or receive care.

I HAVE RECEIVED THE ABOVE DISCLOSURE AND HAVE READ AND UNDERSTAND ITS CONTENTS.

Date: _____

_____

(Signature)

_____

(Print Name)

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(RCW 11.125.400)

I, _____ (insert your name) appoint:

Name: _____

Address: _____

Phone: _____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

If I become unable to make or to communicate a choice regarding a health care decision, my Agent, as my fiduciary, shall have full power and authority to make decisions for me under this Durable Power of Attorney for Health Care to the same extent that I could make such decisions for myself if I had ability to do so. In exercising this authority, my agent shall use his/her best efforts to discuss each proposed decision with me as much as practicable and to determine my desires, whether or not I am able to understand what my agent may be saying and whether or not I am able to respond.

If my Agent cannot determine my then current desires, my agent shall make a decision for me based:

A. Primarily, upon my desires, intentions, and limitations expressed in this Durable Power of Attorney for Health Care and in any Health Care Directive, Directive to Physicians, Living Will, or other health care declaration that I have executed or as otherwise known to my agent, and
B. Secondarily, upon what my agent believes to be in my best interests.

My agent's authority to interpret my desires is intended to be as broad as possible except for the

limitations I state below. Accordingly, unless specifically limited as stated below, my agent shall have all powers conferred upon my agent by law as well as the following power and authority, all exercisable on my behalf and for my benefit:

To consent, to refuse consent, or to withdraw or revoke consent to any care, treatment, service, or procedure (and expressly including withholding or withdrawal of life-sustaining treatment) to maintain, diagnose, or treat a physical, medical, mental, psychological, or psychiatric condition of mine, for example, and not by way of limitation: any medical, surgical, diagnostic, psychological, or psychiatric procedure, treatment, or medication, or any mechanical or other procedure that may affect bodily function, such as artificial respiration, nutritional and hydration support, cardiopulmonary resuscitation, experimental treatment, etc.

To request, gain access to, receive, and review any information, verbal or written, regarding my physical or mental health, including my medical and hospital records and information.

To obtain any information whatsoever regarding my personal affairs or physical or mental health or treatment from any person, facility, or service, including without limitation any physician, hospital, institution, counselor, therapist, nurse, attendant, technician, or personnel, and towards which, I waive any and all privilege over such information in favor of my Agent.

To execute any release or other document, for example, one that may be required in order to obtain the foregoing or other information.

To disclose, or to consent to the disclosure of, any of the foregoing or other information.

To authorize my admission to or discharge (even against medical advice) from any health care facility or service, such as a hospital, nursing home, or residential care, assisted living, mental health, or similar facility or service.

To execute any document or order entitled or purporting to be a "Refusal of Treatment," a "Leaving Health Care Facility Against Medical Advice," a "No Code - Do Not Resuscitate," or

similar document or order.

To execute any necessary waiver or release from liability required by any physician, hospital, or health care provider or facility.

To contract for any health care related product, service, or facility or anything else in furtherance of my desires expressed, or to exercise any power authorized, in this Durable Power of Attorney.

To employ and discharge medical *(e.g.*, physicians, psychiatrists, dentists, etc.), social service (*e.g.*, psychotherapists, mental health counselors, etc.), and other support personnel (*e.g.*, nurses, physical therapists, etc.).

To authorize or to refuse to authorize or to arrange for any medication or procedure, including any medication or procedure intended to relieve pain, even though such use might lead to permanent physical or mental damage or addiction or might hasten the moment of my death.

To authorize or to refuse to authorize or to arrange for any nontraditional or unconventional medication, procedure, or therapy, for example, acupuncture, biofeedback, coetaneous stimulation, guided imagery, or relaxation therapy.

To visit and provide companionship for me and to be accorded the status of a member of my family for purposes of visitation and access to me at any place or in any setting in which the right to be present may be restricted to family members.

To express my desire to reside in my home and, if I am living away from my home, my desire and intent to return to my home if possible and, if not possible or practicable, to a hospice or similar care facility.

To make arrangements for my funeral or memorial services and for the disposition of my remains. I intend that this authorization shall constitute my written direction as regards:

A. Direction of the disposition of my remains following my death under RCW 68.50.160,

B. Disposition under the Uniform Anatomical Gift Act (RCW 68.50.520 through 68.50.620, as amended),
C. Authorization for an autopsy under RCW 68.50.101, as amended, and
D. My funeral services and burial or cremation.

My Agent shall act consistently with my desires as expressed by me during my lifetime, and if my desires are unknown, to act in my best interests. The authority of my agent under this written direction shall not terminate upon my death; however, revocation of this Durable Power of Attorney for Health Care by me during my lifetime shall also revoke the directions made under this written direction under the statutes listed above unless I otherwise ratify them in a separate writing.

To consult with, and obtain information from, members of my family, my physicians and other health care providers or facilities, and my attorneys, accountants and other appropriate persons regarding my health, capacity, or welfare; and towards which, I waive any and all privilege over such information in favor of my agent.

To take any and all other actions necessary or proper to carry out the authorization I have granted to my agent in this Durable Power of Attorney for Health Care; and in furtherance of that grant of authority:

A. To pursue any legal or administrative action in my name and on my behalf at the expense of my estate to compel compliance with my desires as expressed in this Durable Power of Attorney for Health Care or as otherwise determined by my agent; and
B. To seek actual and punitive damages for the failure to comply.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.

A. General Grant of Power and Authority. Subject to any limitations in this Directive, my agent has the power and authority to do all of the following: (1) Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records; (2) Execute on my behalf any releases or other documents that

may be required in order to obtain this information; (3) Consent to the disclosure of this information; and (4) Consent to the donation of any of my organs for medical purposes.

B. HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d and 45 CFR 160 through 164. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to my agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider. (*If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in the section directly below.*)

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

_____

_____

_____

DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent

Name: _____

Address: _____

Phone: _____

B. Second Alternate Agent

Name: _____

Address: _____

Phone: _____

The original of this document is kept at:

_____

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

Any person acting without negligence and in good faith and reasonable reliance on this Durable Power of Attorney for Health Care shall not incur any liability thereby.

All acts done by my Agent under this Durable Power of Attorney for Health Care shall have the same effect and inure to the benefit of and bind me and my estate, heirs, representatives, successors, and assigns as if I had performed such acts personally.

I and my estate hold harmless and indemnify my Agent from all liability for acts done in good faith, not in fraud of me, and in accordance with the power and authority granted by this Durable Power of Attorney for Health Care.

My agent shall be entitled to reimbursement, without Court order, for all reasonable expenses incurred in carrying out the provisions of this Power of Attorney for Health Care but shall not be entitled to compensation for his/her services.

I want every part of this Durable Power of Attorney for Health Care to be fully implemented. If any part is held to be invalid or unenforceable, its remaining provisions shall remain in full effect.

This Durable Power of Attorney for Health Care is made in, and shall be interpreted under the laws of, the State of Washington, although I intend it to be valid in any jurisdiction in which it is presented.

DURATION.

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.
(IF APPLICABLE)
This power of attorney ends on the following date: _____

PRIOR DESIGNATIONS REVOKED.

I revoke any prior Durable Power of Attorney for Health Care.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT.

I have been provided with the above disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

I expressly reserve the right to revoke this Power of Attorney at any time by written instrument signed by me and delivered to my attorney-in-fact/Agent.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this Durable Power of Attorney for Health Care on _____ day of _____ (month, year) at _____ (City and State).

_____

(Signature)

_____

(Print Name)

Attestation

In accordance with RCW 9A.72.085, each of us declares under penalty of perjury under the laws of the State of Washington that the following is true and correct to the best of his/her knowledge:

On the date and at the place shown immediately above, in my presence and in the presence of the other witnesses, the Principal declared this document to be his/her Durable Power of Attorney for Health Care, requested me and the other witness to act as witnesses to his/her signing of the Durable Power, and then signed the Durable Power. Immediately thereafter and at the Principal's request, I and the other witness now sign the Durable Power as witnesses in the presence of the Principal and each other.

The Principal is personally known to me, and I believe him/her to be capable of making health care decisions.

I am not:

- The health care provider, or an employee of the health care provider, of the Principal;
- Financially responsible for the health care of the Principal;
- A creditor of the Principal;
- Related by blood, marriage, or adoption to, or a potential Heir-at-Law of, the Principal; or
- A beneficiary under any valid Will or other estate planning document of the Principal.

Signature | Printed Name & Address

_____ _____

Witness _____

_____

_____ _____

Witness _____

_____

AGENT'S ACCEPTANCE

_____, as attorney in-fact ("Agent") for _____ ("Principal"), accepts and acknowledges delivery to him or her, as Agent, of the foregoing Durable Power of Attorney for Health Care and agrees to be bound thereby.

Dated: _____

_____

_____, Agent

_____

Street Address

_____

City, State ZIP

_____

Telephone Number with Area Code