Durable Power of Attorney for Health Care

My name is _____. My date of birth is _____.

1. **Agent.** I choose (*name*): _____ as my Agent with full authority to manage my health care.

    ☐ **Alternate.** If the agent named above is unable or unwilling to act, I choose (*name*): _____ as my Agent with full authority to manage my health care.

    ☐ **2nd Alternate.** If both the agent and alternate named above are unable or unwilling to act, I choose (*name*): _____ as my Agent with full authority to manage my health care.

2. **My Rights.** I keep the right to make health care decisions for myself if I am capable.

3. **Durable.** My Agent can use this power of attorney to manage my affairs even if I become sick or injured and cannot make decisions for myself. My disability will not affect this power of attorney.

4. **Start Date.** This power of attorney is effective on the day I sign it.

5. **End Date.** This power of attorney will end if I revoke it or when I die. If my spouse or domestic partner is my Agent, this power of attorney will end if either of us files for divorce in court.

6. **Revocation.** I revoke any other power of attorney for health care documents I have signed in the past. I understand that I may revoke this power of attorney at any time by giving written notice of revocation to my Agent.

7. **Powers.** My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including, but not limited to, the power to:

    ✓ Make health care decisions and give informed consent to my health care

    ✓ Refuse and withdraw consent to my health care

    ✓ Employ and discharge my health care providers

    ✓ Apply for and consent to my admission to a medical, nursing, residential, or other similar facility that is **not** a mental health treatment facility

    ✓ Serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended

    ✓ Visit me at any hospital or other medical facility where I reside or receive treatment

8. **Government Benefits.** My Agent shall have full power and authority to arrange for and manage all government benefits on my behalf, including but not limited to signing and consenting to applications, contracts, ongoing eligibility review agreements, and care plans for federal and state cash, food, medical, housing, and long-term care benefits and services.

9. **Mental Health Treatment.** Unless I give my Agent power of attorney for mental health care **and** I have a Mental Health Advance Directive that specifically consents to these things:

   - ✓ My Agent is **not** authorized to arrange for my commitment to or placement in a mental health treatment facility.
   - ✓ My Agent is **not** authorized to consent to electroconvulsive therapy, psychosurgery, or other psychiatric or mental health procedures that restrict physical freedom of movement.

10. **Accounting.** My Agent shall keep accurate records of my financial affairs and show these records to me at my request.

11. **Nomination of Guardian.** I nominate my Agent as my guardian for consideration by the court if guardianship proceedings become necessary.

12. **HIPAA Release.** I authorize my healthcare providers to release all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to my Agent.

I am signing of my own free will for the purposes stated in this document.

▶ _____ _____

My signature (*in front of a notary or witnesses*) Date

Notarization (preferred)

State of Washington
County of _____

This document was acknowledged before me on (*date*) _____
by (*name*) _____.

▶ _____

Signature of Notary
Notary Public for the State of Washington.
My commission expires _____.

Statement of Witnesses (only if you cannot find a notary)

On (*date*): _____, (*name*): _____ signed this Durable Power of Attorney in my presence. I agreed to witness their signature at their request.

- I am not related to this person by blood, marriage, or state registered domestic partnership.
- I do not provide care for this person at home or in a long-term care facility.

Witness 1

▶ _____
Signature

Print name: _____

Address: _____

_____

Phone: _____

Witness 2

▶ _____
Signature

Print name: _____

Address: _____

_____

Phone: _____

Durable Power of Attorney for Health Care
Attachment: Contact Info

My information

My name _____

My date of birth _____

My phone number _____

My email address _____

My mailing address _____

_____

My primary care medical provider

_____

Power of attorney

✓ I have a **Durable Power of Attorney** that lets someone else (my "agent") make health care decisions for me if I am not able.

My health care agent

Agent's name _____

Agent's relationship to me (Examples: friend, partner, spouse, sister, etc.)

_____

Agent's phone number _____

Agent's email address _____

My alternate health care agent (if any)

Alternate's agent's name _____

Alternate agent's relationship to me (friend, partner, spouse, sister, etc.)

_____

Alternate agent's phone number _____

Alternate agent's email address _____

My 2nd alternate health care agent (if any)

2nd alternate's name _____

2nd alternate's relationship to me (friend, partner, spouse, sister, etc.)

_____

2nd alternate's phone number _____

2nd alternate's email address _____