Durable Power of Attorney for Finances
for

_____
[My Name]

1. **Agent.** I choose _____as my Agent with full authority to manage my finances.

2. **Alternate.** If _____is unable or unwilling to act, I choose _____ as my Agent with full authority to manage my finances.

3. **My Rights.** I keep the right to make financial decisions for myself as long as I am capable.

4. **Durable.** My Agent can use this power of attorney document to manage my finances even if I become sick or injured and cannot make decisions for myself. This power of attorney document shall not be affected by my disability.

5. **Start Date.** This power of attorney document is effective: (check one)

   ☐ Immediately.

   ☐ Only if my medical provider signs a letter saying I cannot make decisions for myself.

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

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

8. **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 deposits to, and payments from, any account in my name in any financial institution, to open and remove items from any safe deposit box in my name, to sell, exchange or transfer title to stocks, bonds or other securities, and to sell, convey or encumber any real or personal property. My agent shall also have the following **special powers:** (check all that apply)

- ☐ create, amend, revoke, or terminate a living trust
- ☐ make gifts of my money or property
- ☐ create or change my rights of survivorship
- ☐ create or change my beneficiary designation(s)
- ☐ delegate some authority granted in this document to someone else
- ☐ waive my right to be the beneficiary of an annuity or retirement plan
- ☐ create, amend, revoke, or terminate my community property agreement
- ☐ tell a trustee to make distributions from a trust just as I could

9. **No Power to Agree to Binding Pre-Dispute Arbitration.** I recognize that some long-term-care providers will ask me or my Agent to sign a binding pre-dispute arbitration agreement. These agreements limit my right to sue the provider before any injury or dispute occurs. I think these agreements are unfair and unacceptable. Therefore, my agent does not have the power to agree to pre-dispute binding arbitration or any other process involving my person or property that limits my right to a jury, to sue for money, or to join a class action.

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

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

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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.

_____ _____
My Signature Date

Notarization (optional, but recommended)

State of Washington
County of _____

I certify that I know or have satisfactory evidence that_____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me on _____.

_____
SIGNATURE OF NOTARY

_____
PRINT NAME OF NOTARY

NOTARY PUBLIC for the State of Washington.

My commission expires _____.

Witness 1	Witness 2
_____	_____
Signature	Signature
_____	_____
Name	Name
_____	_____
Address	Address

Durable Power of Attorney for Health Care
for

_____
[My Name]

1. **Agent.** I choose _____as my Agent with full authority to manage my health care.

2. **Alternate.** If _____is unable or unwilling to act, I choose _____as my Agent with full authority to manage my health care.

3. **My Rights.** I keep the right to make health care decisions for myself as long as I am capable.

4. **Durable.** My Agent can still use this power of attorney document to manage my affairs even if I become sick or injured and cannot make decisions for myself. This power of attorney shall not be affected by my disability.

5. **Start Date.** This power of attorney document is effective on the day I sign it in front of a notary public.

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

7. **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 document at any time by giving written notice of revocation to my Agent.

8. **Powers.** My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including 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, and to visit me at any hospital or other medical facility where I reside or receive treatment

9. **Mental Health Treatment.** 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. **No Power to Agree to Binding Pre-Dispute Arbitration.** I recognize that some long-term-care providers will ask me or my Agent to sign a binding pre-dispute arbitration agreement. These agreements limit my right to sue the provider before any injury or dispute occurs. I think these agreements are unfair and unacceptable. Therefore, my agent does not have the power to agree to pre-dispute binding

arbitration or any other process involving my person or property that limits my right to a jury, to sue for money, or to join a class action.

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

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

13. 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.

_____ _____

My Signature Date

Witness 1

_____

Signature

_____

Name

_____

Address

Witness 2

_____

Signature

_____

Name

_____

Address

Notarization (Optional)

State of Washington
County of _____

I certify that I know or have satisfactory evidence that_____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me on _____.

_____

SIGNATURE OF NOTARY

_____

PRINT NAME OF NOTARY
NOTARY PUBLIC for the State of Washington.
My commission expires _____.