

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

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 Healthcare Agent the power to make MOST healthcare decisions for you if you lose the capacity to make informed healthcare decisions for yourself. This power is effective only when you lose the capacity to make informed healthcare decisions for yourself. As long as you have the capacity to make informed healthcare decisions for yourself, you retain the right to make all medical and other healthcare decisions.

You may include specific limitations in this document on the authority of the Healthcare Agent to make healthcare decisions for you.

Subject to any specific limitations you include in this document, if you do lose the capacity to make an informed decision on a healthcare matter, the Healthcare Agent GENERALLY will be authorized by this document to make healthcare decisions for you to the same extent as you would make these decisions yourself if you had the capacity to do so. The authority of the Healthcare Agent to make healthcare 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.

A Healthcare Agent will NEVER be allowed to authorize "mercy killing," euthanasia, or any procedure which would actually speed up the natural process of dying.

When exercising his or her authority to make healthcare decisions for you, the Healthcare Agent will have to act consistent with your express desires, or, if they are unknown, in your best interests. You may express your wishes to the Healthcare Agent by including them in this document or by making them known in another matter.

When acting under this document the Healthcare Agent GENERALLY will have the same rights that you have to receive information about proposed healthcare, to review healthcare records, and to consent to the disclosure of healthcare records. You can limit that right to this document if you choose.

1. Creation of Durable Power of Attorney for Healthcare

I intend to create a power of attorney (Healthcare Agent) by appointing the person or persons designated herein to make healthcare decisions for me to the same extent that I would make such decisions for myself if I was capable of doing so, as recognized by RCW 11.94.010. This designation becomes effective when I cannot make healthcare decisions for myself as documented or determined by my attending physician or designee, such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making healthcare decisions.

2. Designation of Healthcare Agent and Alternate Agents

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

Name _____

Address _____

as my attorney-in-fact (Healthcare Agent) by granting him or her the durable power-of-attorney for healthcare recognized in RCW 11.94.010 and authorize him or her to consult with my physician about the possibility of my regaining the capacity to make healthcare treatment decisions and to accept, plan, stop, and refuse treatment on my behalf with the treating physicians and health personnel.

In the event that _____ is unable or unwilling to serve, I grant these powers to

Name _____

Address _____

_____.

In the event that both _____ and _____ Are unable or unwilling to serve, I grant these powers to

Name _____

Address _____

3. General Statement of Authority Granted

My Healthcare Agent is specifically authorized to give informed consent for healthcare treatment when I am not capable of doing so. This includes but is not limited to consent to initiate, continue, discontinue, or forgo medical care and treatment including artificially supplied nutrition and hydration, following and interpreting my instructions for the provision, withholding, or withdrawing of life-sustaining treatment, which are contained in my Healthcare Directive or other form of Living Will I may have executed or elsewhere, and to receive and consent to the release of medical information. When the Healthcare Agent does not have any stated desires or instructions from me to follow, he or she shall act in my best interests in making healthcare decisions.

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

1. Therapy or other procedure given for the purpose of producing convulsion;
2. Surgery solely for the purpose of psychosurgery.
3. Commitment to or placement in a treatment facility for the mentally ill.
4. Sterilization

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

5. Special Provisions.

Dated this _____ day of _____, year _____.

GRANTOR _____

STATE OF WASHINGTON

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 is and for the State of Washington, residing at

My commission expires
