Health Care Power of Attorney of

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Table of Contents

Article One	**Recitals**	**1**
Section 1.01	Designation of Health Care Agent	1
Section 1.02	Duration	1
Section 1.03	General Grant	2
Section 1.04	Effect on Legal Capacity	2
Article Two	**Health and Personal Powers**	**2**
Section 2.01	Instructions Concerning Medical Evaluations and Treatment	2
Section 2.02	Longterm or Hospice Care	3
Section 2.03	Maintain Me in My Residence	3
Section 2.04	Medical Information and Medical Records	3
Section 2.05	Employ and Discharge Health Care Personnel	3
Section 2.06	Pain Relief	4
Section 2.07	Grant Releases	4
Section 2.08	No Advance Health Care Directive	4
Section 2.09	Agent for Anatomical Gifts and Disposition of Remains	4
Article Three	**Legal and Administrative Powers and Provisions**	**5**
Section 3.01	Health Insurance Portability and Accountability Act	5
Section 3.02	Guardian of my Person	5
Section 3.03	Third-Party Reliance	5
Section 3.04	Enforcement by Health Care Agent	5
Section 3.05	Release of Health Care Agent's Personal Liability	6
Section 3.06	Compensation and Reimbursement of Health Care Agent	6
Section 3.07	Copies Effective as Originals	6
Section 3.08	Interstate Enforceability	6
Section 3.09	Amendment and Revocation	6
Section 3.10	Revocation of Prior Powers	6
Section 3.11	Shall and May	6

I, _________________________________, the principal, an adult of sound mind, execute this Health Care Power of Attorney freely and voluntarily, with an understanding of its purposes and consequences. I intend to create a medical durable power of attorney under the laws of the State of Washington. I further intend to demonstrate my wishes concerning medical treatment with clear and convincing evidence.

I hereby revoke any Health Care Power of Attorney previously granted by me as principal except powers granted by me under any state statutory Health Care Power of Attorney.

Article One
Recitals

Section 1.01 Designation of Health Care Agent

I designate the individual named below to serve as my Health Care Agent. I give my Health Care Agent the power to make decisions with regard to my health care if I am unable to make my own health care decisions.

Name: ____

Phone: ____

If _____________________________________ is unwilling or unable to serve, I designate the individuals in the order listed below as alternate Health Care Agents to exercise the powers and discretions set forth in this instrument.

Name: ____

Phone: ____

Name: ____

Phone: ____

Section 1.02 Duration

This Health Care Power of Attorney expires at the earliest of:

my death (except for post-death matters allowed under Washington law); or

my revocation of this Health Care Power of Attorney.

However, the medical information and medical records provisions described in Section 2.04 shall continue in effect for an additional 9 months from the date of my death unless revoked. My Health Care Agent’s authority does not terminate if I become disabled or incapacitated.

Section 1.03 General Grant

My Health Care Agent may determine and implement all actions necessary for my personal care, residential placement, and medical treatment, including the items specifically mentioned in this instrument. If my Health Care Agent is not available, I intend to guide decisions about my care and treatment with the following statements.

Section 1.04 Effect on Legal Capacity

A formal adjudication of my incapacity is not required for my Health Care Agent to exercise the authority granted by me under this instrument.

Article Two
Health and Personal Powers

Section 2.01 Instructions Concerning Medical Evaluations and Treatment

In exercising the authority granted to my Health Care Agent, I instruct my Health Care Agent to discuss with me the specifics of any proposed decision regarding my medical care and treatment if I am able to communicate in any manner however rudimentary, even by blinking my eyes. I further instruct my Health Care Agent that if I am unable to give an informed consent to medical treatment, my Health Care Agent shall give or withhold consent based upon any treatment choices I have expressed while competent, whether under this instrument or otherwise. If my Health Care Agent cannot determine the treatment choice I would want made under the circumstances, then I request that my Health Care Agent make the choice for me based upon what my Health Care Agent believes to be in my best interests. I request that my Health Care Agent's decision be guided by taking into account:

> the provisions of this instrument;
>
> any preferences that I may have expressed on the subject;
>
> what my Health Care Agent believes I would want done in the circumstances if I were able to express myself; and
>
> any information given to my Health Care Agent by the physicians treating me as to my medical diagnosis and prognosis and the intrusiveness, pain, risks, and side effects of the treatment.

I want to leave my family, friends, and persons who care about me with assurances of my love, and without the burdens of guilt or conflict. My purposes in leaving these instructions are to alleviate uncertainty that otherwise may arise in connection with decisions about my medical care, to promote family harmony, and to clarify instructions to my health care providers. My Health Care Agent's authority to act on my behalf concerning my medical care includes, even if my Health Care Agent's exercise of such authority hastens the moment of my death, decisions concerning: artificial life support; medical treatment; surgery and other medical procedures; artificial nourishment and hydration; food and water

if I have advanced dementia; resuscitation decisions (including Do Not Resuscitate [DNR] orders and Cardiopulmonary Resuscitation [CPR] directives); amputation of my limbs; blood transfusions; experimental drugs and medical procedures; the administration of pharmaceutical agents; and arrangements for my longterm care.

I affirm my belief in the importance and value of my personal dignity, both in living and in dying.

Section 2.02 Longterm or Hospice Care

My Health Care Agent may select a facility for my nursing, convalescent, or hospice care and establish my residence and placement in a secure unit therein if the facility provides the quality of care appropriate for my medical needs and mental condition. For the purposes of arranging or providing long-term care, my Health Care Agent has authority to facilitate my transportation and establish my legal residence within or beyond the state of Washington.

Section 2.03 Maintain Me in My Residence

I authorize my Health Care Agent to take whatever steps are necessary or advisable to enable me to remain in my personal residence as long as it is reasonable under the circumstances. I realize that my health may deteriorate so that it becomes necessary to have round-the-clock nursing care if I am to remain in my personal residence, and I direct my Health Care Agent to obtain that care, including any equipment that might assist in my care, as is reasonable under the circumstances. Specifically, I do not want to be hospitalized or put in a convalescent or similar home as long as it is reasonable to maintain me in my personal residence.

Section 2.04 Medical Information and Medical Records

Acting on my behalf, my Health Care Agent may have access to all of my medical information and photocopies of my medical records from my health care providers including physicians, dentists, podiatrists, physical therapists, chiropractic physicians and chiropractors, pharmacists, optometrists, psychologists, social workers, hospitals, hospices, and other treatment facilities; may disclose medical and related information concerning my treatment to appropriate health care providers; and may admit or transfer me to such hospitals, hospices, or treatment facilities as my Health Care Agent determines to be in my best interests.

In order for my Health Care Agent to fulfill his or her duties, my treating physician or hospital is to discuss my medical condition with and disclose all medical records to my Health Care Agent.

Section 2.05 Employ and Discharge Health Care Personnel

My Health Care Agent may employ and discharge medical personnel including physicians, psychiatrists, dentists, nurses, and therapists as my Health Care Agent determines necessary for my physical, mental, and emotional well-being, and pay them reasonable compensation.

Section 2.06 Pain Relief

I want to ensure that my Health Care Agent and physician protect my comfort and freedom from pain insofar as possible. I authorize my Health Care Agent to consent on my behalf to the administration of whatever pain-relieving drugs and pain-relieving surgical procedures my Health Care Agent, upon medical advice, believes may provide comfort to me, even though such drugs or procedures may lead to pharmaceutical addictions, lower blood pressure, lower levels of breathing, or hasten my death. Even if artificial life support or aggressive medical treatment has been withdrawn or refused, I want to be kept as comfortable as possible, and I do not want to be neglected by medical or nursing staff.

Section 2.07 Grant Releases

My Health Care Agent may grant, in conjunction with any instructions given under this instrument, releases from all liability for damages suffered or to be suffered by me to hospital staff, physicians, nurses, and other medical and hospital administrative personnel who act in reliance on instructions given by my Health Care Agent or who render written opinions to my Health Care Agent in connection with any matter described in this instrument. My Health Care Agent may sign documents titled or purporting to be a *Refusal to Permit Treatment* and *Leaving Hospital Against Medical Advice* as well as any necessary waivers of or releases from liability required by any hospital or physician to implement my wishes regarding medical treatment or nontreatment.

Section 2.08 No Advance Health Care Directive

At the time of my execution of this document, I have not executed an Advance Health Care Directive. If I become unconscious or incompetent in a state where this Health Care Power of Attorney is not enforceable, I authorize my Health Care Agent to transport me or arrange for my transportation to a jurisdiction where my medical directives will be enforceable.

Section 2.09 Agent for Anatomical Gifts and Disposition of Remains

To the extent I have not provided for anatomical gifts in my Will, I appoint and authorize the person acting as my Health Care Agent at the time of my death as my agent to make anatomical gifts on my behalf under RCW Chapter 68.64, including the execution of any papers, and acting as necessary, appropriate, incidental, or convenient in connection with these gifts.

To the extent I have not provided for disposition of my remains in my Will, I appoint and authorize the person acting as my Health Care Agent at the time of my death as my designated agent, under RCW Chapter 68.50, to direct the disposition of my remains.

This Section shall survive termination of this Health Care Power of Attorney by reason of my death.

Article Three
Legal and Administrative Powers and Provisions

Section 3.01 Health Insurance Portability and Accountability Act

I grant my Health Care Agent the power and authority to serve as my authorized recipient for all purposes of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its regulations immediately upon my signing this document.

Pursuant to HIPAA, I specifically authorize my Health Care Agent as my HIPAA-authorized recipient to request, receive, and review any information regarding my physical health, including all HIPAA-protected health information, medical, and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required to obtain this information; and to consent to the disclosure of this information. I further authorize my Health Care Agent to execute on my behalf valid authorizations for the release of HIPAA-protected health information.

By signing this Health Care Power of Attorney, I specifically authorize my physician, hospital, or health care provider to release any medical records to my Health Care Agent or any person designated in a valid authorization for the release of HIPAA-protected health information executed by my Health Care Agent. Further, I waive any liability to any physician, hospital, or health care provider that releases any of my medical records to my Health Care Agent and acknowledge that the health information that would otherwise be protected under HIPAA will no longer be protected.

Section 3.02 Guardian of my Person

My Health Care Agent's authority precludes the need for appointment of a Guardian of my person. But if any proceeding is commenced for the appointment of a Guardian of my person, I nominate my Health Care Agent to serve as Guardian of my person.

Section 3.03 Third-Party Reliance

My Health Care Agent's instructions and decisions regarding my medical treatment are binding on third parties. No person, medical facility, or institution will incur any liability to me or to my estate by complying with my Health Care Agent's instructions. My Health Care Agent is authorized to execute consents, waivers, and releases of liability on my behalf and on behalf of my estate to all medical personnel who comply with my Health Care Agent's instructions. Furthermore, I authorize my Health Care Agent to indemnify and hold harmless, at my expense, any third party who accepts and acts under this Health Care Power of Attorney, and I agree to be bound by any indemnity entered into by my Health Care Agent.

Section 3.04 Enforcement by Health Care Agent

I authorize my Health Care Agent to seek on my behalf and at my expense:

> a declaratory judgment from any court of competent jurisdiction interpreting the validity of this instrument or any of the acts authorized by this instrument, but a declaratory judgment is not required for my Health Care Agent to perform any act authorized by this instrument;

an injunction requiring compliance with my Health Care Agent's instructions by any person providing medical or personal care to me; or

actual and punitive damages against any person responsible for providing medical or personal care to me who willfully fails or refuses to follow my Health Care Agent's instructions.

Section 3.05 Release of Health Care Agent's Personal Liability

My Health Care Agent will not incur any personal liability to me or my estate arising from the good faith exercise of discretion or performance of acts and duties relating to my medical treatment and personal care.

Section 3.06 Compensation and Reimbursement of Health Care Agent

My Health Care Agent is entitled to reasonable compensation for services performed, and to reimbursement for reasonable expenses incurred, in carrying out the provisions of this instrument.

Section 3.07 Copies Effective as Originals

Photocopies of this instrument are effective and enforceable as originals, and third parties are entitled to rely on photocopies of this instrument for the full force and effect of all stated terms. The word *photocopies* includes facsimiles, digital, or other reproductions.

Section 3.08 Interstate Enforceability

My intention is that the terms of this instrument be honored in any jurisdiction, regardless of its conformity to that jurisdiction's technical requirements and legal formalities.

Section 3.09 Amendment and Revocation

I reserve the right to amend or revoke my Health Care Power of Attorney in writing.

Section 3.10 Revocation of Prior Powers

Unless specifically excepted in this instrument, this Health Care Power of Attorney supersedes any prior medical durable power of attorney that I have executed. But this instrument does not affect any other unrelated powers previously conveyed by me through general or limited powers of attorney, or my Advance Health Care Directive; these powers and Advance Health Care Directive are to continue in full force until revoked by me or otherwise terminated.

Section 3.11 Shall and May

Unless otherwise specifically provided in this document or by the context in which used, I use the word *shall* in this document to impose a duty, command, direction, or requirement, and the word *may* to allow or permit, but not require. In the context of my Health Care Agent, when I use the word *shall,* I intend to impose a fiduciary duty on my Health Care Agent. When I use the word *may*, I intend that my Health Care Agent is empowered to act with sole and absolute discretion unless otherwise stated in this document.

Dated: ___________________________

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___________________________________, **Principal**
(print name)

I declare that I witnessed ___________________________________ sign this health care power of attorney and that, to my best knowledge and belief, he / she was of sound mind. In addition, I am not the attending physician, an employee of the attending physician or health care facility in which Principal is a patient, or any person who has a claim against any portion of the estate of Principal upon Principal's decease at the time of the execution of the health care power of attorney.

Witness	**Witness**
_____________________________________	_____________________________________
Sign	Sign
_____________________________________	_____________________________________
Print Name	Print Name
_____________________________________	_____________________________________
_____________________________________	_____________________________________
Address	Address

STATE OF WASHINGTON)
) ss.
COUNTY OF ________________________)

On this day, _________________________________, I certify that I know or have satisfactory evidence that ___________________________, the Principal, and _________________________ and _________________________, the witnesses, are the persons who appeared before me, and said persons signed this instrument and acknowledged it to be their free and voluntary act for the uses and purposes mentioned in the instrument.

Witness my hand and official seal

____

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Notary Public for the State of Washington

Residing at ________________________

My commission expires ______________