MultiCare

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Please print your full name: _____

Please provide your full date of birth: _____

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 Health Care Agent the power to make MOST health care decisions for you if you lose the capability to make informed health care decisions for yourself. This power is effective only when you lose the capacity to make informed health care decisions for yourself. As long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions.
- You may include specific limitations in this document on the authority of the Health Care Agent to make health care 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 health care matter, the Health Care Agent GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the Health Care Agent to make health care 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 Health Care Agent will NEVER be allowed to authorize "mercy killing," also known as "euthanasia."
- When exercising his or her authority to make health care decisions for you, the Health Care Agent will have to act consistent with your expressed desires or, if they are unknown, in your best interest. You may express your desires to the Health Care Agent by including them in this document or by making them known in another manner.
- When acting under this document the Health Care Agent GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you choose.

1. Creation of Durable Power of Attorney for Health Care

I intend to create a durable power of attorney (Health Care Agent) by appointing the person or persons designated herein to make health care decisions for me to the same extent that I could make such decisions for myself if I was capable of doing so, as recognized by RCW 11.94.010, as amended by Senate Bill 5635 . This designation becomes effective at any time that my physicians determine that I am unable to make health care decisions for myself such as if I am unconscious, or if I am otherwise temporarily or permanently incapable of making health care decisions. The authority conferred shall not be effected by my incapacity or disability, it being my intent that this durable power of attorney remain in effect at all times that I am unable to make health care decisions. The Health Care Agent's power shall cease if and when I regain my capacity to make health care decisions but any decisions made on my behalf prior to regaining capacity shall be fully valid and shall remain in effect in the same manner, and for the same extent, as if I had made those decisions myself.

2. Designation of Health Care Agent and Alternate Agents

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

_____

(Name) (Address) (City) (State) (Zip) (Phone

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

87-6030-2e B (Rev. 12/16)

Please print your full name as you did on page 1: _____

Please provide your full date of birth: _____

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

_____
(Name) (Address) (City) (State) (Zip) (Phone)

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

_____
(Name) (Address) (City) (State) (Zip) (Phone)

3. General Statement of Authority Granted: My Health Care Agent is specifically authorized to give informed consent for health care treatment when I am not capable of doing so. This includes but is not limited to consent to initiate, continue, discontinue, or forego 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 any Health Care 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 Health Care Agent does not have any stated desires or instructions from me to follow, he or she shall act in my best interest in making health care decisions.

The above authorization to make health care decisions does not include the following absent a court order: 1) Therapy or other procedure given for the purpose of inducing convulsion; 2) Surgery solely for the purpose of psychosurgery; 3) Commitment to or placement in a treatment facility for the mentally ill, except pursuant to the provisions of Chapter 71.05 RCW; 4) Sterilization.

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

4. Special Provisions (*Attach Additional Pages As Needed)* _____

_____

DATED this _____ day of _____, _____.
(Year)

Washington State requires that a Durable Power of Attorney for Health Care be notarized or witnessed. Some states require it to be notarized, so you may want to do so in the event you travel out of state. If witnessed, it must be witnessed by two witnesses meeting specific statutory requirements (generally not related by blood, marriage or any form of domestic partnership, and not providers of home health care, skilled nursing care or adult family home services where you reside).

GRANTOR _____

STATE OF WASHINGTON)
ss.
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 in and for the State of Washington, residing at _____ .

My commission expires _____.

Alternative: Two Statutory Witnesses meeting the criteria of Senate Bill 5635 may witness this Durable Power of Attorney for Health Care, in lieu of the use of a notary. The witnesses may not be related by blood, marriage or domestic partnership and may not be providers of home health care, skilled nursing care or adult family home services where the principal resides.

Attestation of Witnesses:
On this date, we witnessed _____, the person (Grantor) who signed the within and foregoing Durable Power of Attorney, sign the Durable Power of Attorney for Health Care in our presence, and who appeared to be of sound mind and not subject to any form of coercion or undue influence.

Witness One: Signature: _____ Print Name: _____ Date: _____

Relationship to Grantor: _____ Write "None" if no prior relationship to the Grantor.

Contact Information: (Address and/or Phone Contact Info) _____

Witness Two: Signature: _____ Print Name: _____ Date: _____

Relationship to Grantor: _____ Write "None" if no prior relationship to the Grantor.

Contact Information: (Address and/or Phone Contact Info) _____