Advance Directive: Durable Power of Attorney for Health Care

This advance directive, a durable power of attorney for health care, allows you to name and prepare your health care agent. This form meets the requirements of Washington state law.

My information:

FULL NAME: PRONOUNS (optional):
(i.e., he/she/they)

ADDRESS, CITY, STATE, ZIP:

DATE OF BIRTH: / /
(mm/dd/yyyy)

NAMING A HEALTH CARE AGENT

The person I designate as my health care agent is:

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

The people I designate as my alternate agents are:

If the person listed above is unable or unwilling to make my health care decisions, then I designate the people listed below as my first and second alternate health care agents.

First alternate

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

Second alternate

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

WSMA Washington State Medical Association
Physician Driven, Patient Focused

PRINTED NAME:

DATE OF BIRTH: / /
(mm/dd/yyyy)

Guidance for my health care agent:

Write information you want your health care agent to know about your health care wishes.

AUTHORIZING A HEALTH CARE AGENT

Authority I give my agent: I grant my agent complete authority to make all decisions about my health care. This includes, but is not limited to (a) consenting, refusing consent, and withdrawing consent for medical treatment recommended by my physicians, including life-sustaining treatments; (b) requesting particular medical treatments; (c) employing and dismissing members of the health care team; (d) changing my health care insurers; (e) signing a Portable Orders for Life-Sustaining Treatment (POLST) form; (f) transferring me to or placing me in another facility, private home, or other places; and (g) accessing my medical records and information.

I attest to the following: I understand the importance and meaning of this durable power of attorney for health care (DPOA-HC). This form reflects my health care agent choices and my goals, values, and preferences. I have filled out this form willingly. I am thinking clearly. I understand that I can change my mind at any time. I understand I can revoke and replace this form at any time. I revoke any prior durable power of attorney for health care. I want this DPOA-HC to become effective if a physician or licensed psychologist determines I do not have the capacity to make my own health care decisions. This directive will continue as long as my incapacity lasts.

MY SIGNATURE: DATE:

Witnesses or notary requirement

You must have your signature either witnessed by two people or acknowledged by a notary public.

OPTION 1 – TWO WITNESSES

Witness attestation: I declare I meet the rules for being a witness.

WITNESS #1 SIGNATURE: DATE:

NAME PRINTED:

WITNESS #2 SIGNATURE: DATE:

NAME PRINTED:

Rules for witnesses:

- Must be at least 18 years of age and competent.
- Cannot be related to you or your health care agent by blood, marriage, or state-registered domestic partnership.
- Cannot be your home care provider or a care provider at an adult family home or long-term care facility where you live.
- Cannot be your designated health care agent.

OPTION 2 – NOTARY

STATE OF WASHINGTON)
)
COUNTY OF _____)

This record was acknowledged before me on this day of ,

by (name of individual):

Signature: Title: Exp:

PRINTED NAME:

DATE OF BIRTH: / /
(mm/dd/yyyy)

REV 05/2024