持久醫療保健授權書

我的姓名是 _____。

我的出生日期是 _____。

1. 代理人。我選擇（*姓名*）：

_____，

作為我的代理人，全權管理我的醫療保健服務。）

☐ **後備代理人。**如果上述代理人 無法或不願執行授權，我選擇（*姓名*）：

_____

作為我的代理人，全權管理我的醫療保健服務。

☐ **第 2 名候補代理人。**如果上述代理人和後備代理人無法或不願執行授權，我選擇（*姓名*）：

_____

作為我的代理人，全權管理我的醫療決策。

2. 我的權利。只要我仍有能力，我就會保留自行做出醫療保健決定的權利。

3. 持久性。假如我生病或受傷，而且無法自行做出決定，我的代理人可以使用這份授權文件管理我的醫療保健服務。我的殘疾狀態不會影響本授權書的效力。

4. 開始日期。本授權書自本人簽字之日起生效。

5. 失效日期。如果我撤銷該授權或者去世，則本授權書失效。如果我的代理人是配偶或同居伴侶，則其中任何一方在法庭上提出離婚時，本授權書即失效。）

Durable Power of Attorney for Health Care

My name is _____.

My date of birth is _____.

Agent. I choose (*name*):

_____

as my Agent with full authority to manage my health care.

Alternate. If the agent named above is unable or unwilling to act, I choose (*name*):

_____ as my Agent with full authority to manage my health care.

2nd Alternate. If both the agent and alternate named above are unable or unwilling to act, I choose (*name*):

_____

as my Agent with full authority to manage my health care.

My Rights. I keep the right to make health care decisions for myself if I am capable.

Durable. My Agent can use this power of attorney to manage my affairs even if I become sick or injured and cannot make decisions for myself. My disability will not affect this power of attorney.

Start Date. This power of attorney is effective on the day I sign it.

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

6. **撤銷**。我撤銷我過去簽署的任何其他醫療服務授權書文件。我知悉我可以隨時透過向我的代理人發出書面撤銷通知來撤銷此授權。

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

7. **權力**。我的代理人應獲得全面權力和授權，以充分且有效地執行本人可以進行的任何操作，包括但不限於：

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:

- ✓ 對我的醫療保健做出決策並提供知情同意書

  Make health care decisions and give informed consent to my health care

- ✓ 拒絕和撤銷我的醫療服務同意書

  Refuse and withdraw consent to my health care

- ✓ 僱用和解除我的醫療服務提供者

  Employ and discharge my health care providers

- ✓ 申請並同意我入住**非**精神衛生類治療機構的醫療、護理、居住或其他類似設施

  Apply for and consent to my admission to a medical, nursing, residential, or other similar facility that is **not** a mental health treatment facility

- ✓ 作為我的個人代表執行修訂版《1996 年健康保險攜帶和責任法案》（HIPAA)下的所有職責

  Serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended

- ✓ 到我居住或接受治療的任何醫院或其他醫療設施進行探視

  Visit me at any hospital or other medical facility where I reside or receive treatment

8. **政府福利**。我的代理人應擁有充分的權力和權限，代表我對政府福利作出安排並進行管理，包括但不限於簽署及同意與聯邦和州政府現金、食品、醫療、住房以及長期護理福利和服務有關的申請、合約、持續資格審查協議以及護理計畫。

Government Benefits. My Agent shall have full power and authority to arrange for and manage all government benefits on my behalf, including but not limited to signing and consenting to applications, contracts, ongoing eligibility review agreements, and care plans for federal and state cash, food, medical, housing, and long-term care benefits and services.

9. 精神健康治療。我的代理人**無權**安排將我禁錮於或安置在精神健康治療機構。我的代理人**無權**同意電休克療法、精神外科手術或其他限制身體行動自由的精神病學或心理健康程序。	**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. 賬目。我的代理人應保管我的準確財務記錄，並在我索要時出示這些記錄。	**Accounting.** My Agent shall keep accurate records of my financial affairs and show these records to me at my request.
11. 監護人提名。我提名將我的代理人作為我的監護人，在需要執行財產保管程序時提請法院進行考慮。	**Nomination of Guardian.** I nominate my Agent as my guardian for consideration by the court if guardianship proceedings become necessary.
12. HIPAA（健康保險攜帶和責任法案）披露。我授權我的醫療服務提供者向我的代理人披露受《 1996 年健康保險攜帶和責任法案 》（HIPAA） 管轄的所有信息。	**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.
本文件於*（日期）*__在我面前得到確認。	I am signing of my own free will for the purposes stated in this document.

日期：_____	← Date
▶ _____	← My signature (in front of a notary or witnesses)
我的簽名（在公證人或證人面前）	

公證 *(Notarization)*

State of Washington *（Washington 州）*

County of *（所在郡）* _____

This document was acknowledged before me on (*date*) _____

以下人員在我面前簽字或證明（日期）

by (*name*) *人員（姓名）* _____。

▶ _____

Signature of Notary（公證員簽字）

Notary Public for the State of Washington.

（Washington州公證員。）

My commission expires *（公證職責截止日期）*

_____

見證人聲明

（僅適用於無法找到公證人之情況）

（*日期*）_____，（*姓名*）_____
在我面前簽署本持久授權書。在其要求下，我同意作为他們的簽名見證人。

- 我與該當事人沒有血緣關係、婚姻關係或在州政府註冊的同居伴侶關係。
- 我沒有該當事人提供居家或長期護理機構護理服務。

見證人 1

_____
簽名

_____
正楷體姓名

地址 _____

_____

電話 _____

證人 2

_____
簽名

_____
正楷體姓名

地址 _____

_____

電話 _____

Statement of Witnesses
(only if you cannot find a notary)

On (*date*) _____, (*name*) _____ signed this Durable Power of Attorney in my presence. I agreed to witness their signature at their request.

I am not related to this person by blood, marriage, or state registered domestic partnership.

I do not provide care for this person at home or in a long-term care facility.

Witness 1

← Signature

← Print name

← Address

← Phone

Witness 2

← Signature

← Print name

← Address

← Phone

持久醫療保健授權書

附件：聯繫資訊

Durable Power of Attorney for Health Care

Attachment: Contact Info

我的資訊 / My information

我的姓名 _____ / My name

我的出生日期 _____ / My date of birth

我的電話號碼 _____ / My phone number

我的電子郵箱 _____ / My email address

我的郵寄地址 _____ / My mailing address

_____

我的初級保健醫生 / My primary care medical provider

_____

授權書 / Power of attorney

我簽署過一份**《持久授權書》**，可以讓其他人（我的「代理人」）在我失能時為我作出醫療決策。

I have a **Durable Power of Attorney** that lets someone else (my "agent") make health care decisions for me if I am not able.

我的醫療決策代理人 / My health care agent

代理人姓名_____ / Agent's name

我的代理人與我的關系（例如朋友、伴侶、配偶、姐妹等） / My agent's relationship to me (Examples: friend, partner, spouse, sister, etc.)

_____

我的代理人電話號碼 _____ / My agent's phone number

我的代理人電子郵件地址 _____ / My agent's email address

我的醫療決策後備代理人（如果有） / My alternate health care agent (if any)

後備代理人姓名_____ / Alternate agent's name

我的後備代理人與我的關系（例如朋友、伴侶、配偶、姐妹等） _____	My alternate agent's relationship to me (Examples: friend, partner, spouse, sister, etc.)
我的後備代理人電話號碼 _____	My alternate agent's phone
我的後備代理人電子郵件地址 _____	My alternate agent's email
我的醫療決策後備代理人（如果有）	**My 2nd alternate health care agent's name (if any)**
第 2 名後備代理人姓名_____	2nd alternate's name
我的後備代理人與我的關系（朋友、伴侶、配偶、姐妹等）_____	2nd alternate's relationship to me (Examples: friend, partner, spouse, sister, etc.)
第 2 名後備代理人電話號碼_____	2nd alternate's phone
第 2 名後備代理人電子郵件地址_____	2nd alternate's email