持久授权书

(Durable power of attorney)

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Last Review Date

October 17, 2024

授权书让您可以选择一位值得信赖的朋友或亲戚帮助您做出财务和/或医疗服务方面的决定。（授权书及说明）

Fill out forms online

- Durable Power of Attorney (Finances and/or Health Care)

Form attached:

持久医疗保健授权书 (NJP Planning 501 ZH-CN)

Form attached:

持久财务授权书 (NJP Planning 500 ZH-CN)

什么是授权委托书?

授权书让您可以选择一位值得信赖的朋友或亲戚帮助您做出财务和/或医疗服务方面的决定。签署后，您所选择的人员会把授权书交给您的医疗机构、银行、学校和其他地方，以便像您本人一样做出决定和签订合同。

您所选择的帮您做出财务和/或医疗服务决定的值得信赖的朋友或亲戚，称为您的“代理人”。

如果授权书指出，假如您因生病或受伤而无法自行做出决定时，代理人仍可以使用该文件，则该授权书具有“持久性”。

我是否需要在公证员面前签署授权书?

您应该在公证员面前签署您的持久授权书。如果找不到公证员，您可以在两位“无利害关系”的见证人面前签名。然而，公证是首选，特别是对于持久财务授权书。

签署该授权书后我该怎么做?

签署表格后，请复印2份。将原始表格交给您的代理人，将一份副本交给您的后备代理人，您自己保留第二份副本。

我能否更改我的授权书并选择一名新代理人?

可以。您可以随时通过向您的代理人发出书面通知来取消（撤销）您的授权。

您在撤销授权委托书后，您可以签署一份新的授权委托书表格，选择一位不同的代理人。在您的新授权委托书中，务必声明先前所有的旧授权委托书已被撤销。

如果银行不接受我的授权书该怎么办?

有时银行或其他商业机构会告诉代理人他们不接受您的授权委托书。两种常见原因可能造成这种情况：

1. **授权委托书未公证。**Washington州法律规定，在公证人**或**两名“无利害关系”的证人面前签署的授权书有效。但一些银行或其他商业机构坚决要求授权书**必须**经过公证。您可以在公证人面前签署一份新授权书。但您的代理人也可以要求与其法律部门对话，并指出《修订版Washington州法典》（RCW）第11.125.050节(https://app.leg.wa.gov/RCW/default.aspx?cite=11.125.050)规定。如果授权书没有经过公证，而是在两名“无利害关系”的证人见证下签署，则根据Washington州法律，该授权书依然有效。您的银行**应该**接受它。
2. **委托授权书不“正确”。**本页授权委托书在Washington州法律下有效，但一些银行和其他商业机构希望您使用他们自己的授权书表格。如果银行或其他商业机构不接受您的授权委托书，您的代理人可以要求与其法律部门对话，并指明RCW 11.125.050(https://app.leg.wa.gov/RCW/default.aspx?cite=11.125.050)和RCW 11.125.200（3）（a）(https://app.leg.wa.gov/RCW/default.aspx?cite=11.125.200)之规定。

可能要求代理人出具保证书。

银行可能表示，只有代理人签署一份“保证书”确认该授权书有效后，他们才会接受。这样做是合法的。但是，如果银行需要一份保证书，他们必须您提供授权书7日内提出该要求。只有代理人才能签署该保证书。

如果银行或机构拒绝您的授权书或者要求您使用他们自己的授权书表格，则应尽量寻求法律帮助。

持久医疗保健授权书

我的姓名是 _____。

我的出生日期 _____。

1. **代理人。**我选择（*姓名*）

   _____

   作为我的代理人，全权管理我的医疗保健服务。

   ☐ **后备代理人。**如果上述代理人无法或不愿执行授权，我选择（*姓名*）_____ 作为我的代理人，全权管理我的医疗保健服务。

   ☐ **第 2 名候补代理人。**如果上述代理人和候补代理人无法或不愿执行授权，我选择（姓名）：
   作为我的代理人，全权管理我的医疗决策。

2. **我的权利。**只要我仍有能力，我就会保留自行做出医疗保健决定的权利。

3. **持久性。**假如我生病或受伤，而且无法自行做出决定，我的代理人可以使用这份授权文件管理我的医疗保健服务。我的残疾状态不会影响本授权书的效力。

4. **开始日期。**本授权书自本人签字之日起生效。

5. **失效日期。**如果我撤销该授权或者去世，则本授权书失效。如果我的代理人是配偶或同居伴侣，则其中任何一方在法庭上提出离婚时，本授权书即失效。

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. **撤销。**我撤销我过去签署的任何其他医疗服务授权书文件。我知悉我可以随时通过向我的代理人发出书面撤销通知来撤销此授权。

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. **权力。**我的代理人应获得全面权力和授权，以充分且有效地执行本人可以进行的任何操作，包括但不限于：

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:

- ✓ 对我的医疗保健做出决策并提供知情同意书

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

- ✓ 拒绝和撤销我的医疗服务同意书

  Refuse and withdraw consent to my health care

- ✓ 僱用和解除我的医疗服务提供者

  Employ and discharge my health care providers

- ✓ 申请并同意我入住**非**精神卫生类治疗机构的医疗、护理、居住或其他类似设施

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

- ✓ 作为我的个人代表执行修订版《1996 年健康保险携带和责任法案》（HIPAA)下的所有职责

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

- ✓ 到我居住或接受治疗的任何医院或其他医疗设施进行探视

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

8. **政府福利。**我的代理人应拥有充分的权力和权限，代表我对政府福利作出安排并进行管理，包括但不限于签署并同意与联邦和州政府现金、食品、医疗、住房以及长期护理福利和服务相关的申请、合约、持续资格审查协议以及护理计划。

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. **精神健康治疗。**我的代理人**无权**安排将我禁锢于或安置在精神健康治疗机构。我的代理人**无权**同意电休克疗法、精神外科手术或其他限制身体行动自由的精神病学或心理健康程序。	**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. **账目。**我的代理人应保管我的准确财务记录，并在我索要时出示这些记录。	**Accounting.** My Agent shall keep accurate records of my financial affairs and show these records to me at my request.
11. **监护人提名。**我提名将我的代理人作为我的监护人，在需要执行财产保管程序时提请法院进行考虑。	**Nomination of Guardian.** I nominate my Agent as my guardian for consideration by the court if guardianship proceedings become necessary.
12. **HIPAA（健康保险携带和责任法案）披露。**我授权我的医疗服务提供者向我的代理人披露受《1996 年健康保险携带和责任法案 》（HIPAA） 管辖的所有信息。	**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.
我自愿签署本人意愿用于本文件所述之目的。	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)
我的签名（在公证员或见证人面前）	

Notarization (公证)

State of Washington *(Washington 州)*

County of *(所在郡)* _____

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

本文档已于（日期）___ 在我面前得到确认。

by (*name*) /*人员（姓名）* _____。

▶ _____

Signature of Notary *(公证员签字)*

Notary Public for the State of Washington.

(Washington州公证员。)

My commission expires *(公证职责截止日期)*

_____

见证人声明
（仅适用于无法找到公证员之情况）

（日期）_____，姓名）_____
在我面前签署本持久授权书。在其要求下，我同意作为他们的签名见证人。

- 我与该当事人没有血缘关系、婚姻关系或在州政府注册的同居伴侣关系。
- 我没有为该当事人提供居家或长期护理机构护理服务。

见证人 1

▶ _____
签名

_____
正楷体姓名

地址 _____

_____

电话 _____

见证人 2

▶ _____
签名

_____
正楷体姓名

地址 _____

_____

电话 _____

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

持久医疗保健授权书
附件：联系信息

Durable Power of Attorney for Health Care
Attachment: Contact Info

我的信息

My information

我的姓名 _____

My name

我的出生日期_____

My date of birth

我的电话号码_____

My phone number

我的电子邮箱_____

My email address

我的邮寄地址_____

_____

My mailing address

我的初级保健医生 _____

My primary care medical provider

授权书

Power of attorney

我签署过一份**《持久授权书》**，可以让其他人（我的“代理人”）在我失能时为我作出医疗决策。

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

My health care agent

代理人姓名_____

Agent’s name

我的代理人与我的关系（例如朋友、伴侣、配偶、姐妹等）

_____

My agent’s relationship to me (Examples: friend, partner, spouse, sister, etc.)

我的代理人电话号码 _____

My agent’s phone number

我的代理人电子邮件地址 _____

My agent’s email address

我的医疗决策候补代理人（如果有）

My alternate health care agent (if any)

候补代理人姓名_____

Alternate agent’s name

我的后备代理人与我的关系（例如朋友、伴侣、配偶、姐妹等）

_____

My alternate agent’s relationship to me (Examples: friend, partner, spouse, sister, etc.)

我的后备代理人电话号码 _____

My alternate agent’s phone

我的后备代理人电子邮件地址 _____

My alternate agent’s email address

我的第 2 名医疗决策候补代理人（如果有）	**My 2nd alternate health care agent (if any)**
第 2 名候补代理人姓名 _____	2nd alternate's name
第 2 名候补代理人与我的关系（朋友、伴侣、配偶、姐妹等）） _____	2nd alternate's relationship to me (Examples: friend, partner, spouse, sister, etc.)
第 2 名候补代理人电话号码_____	2nd alternate's phone
第 2 名候补代理人电子邮件地址_____	2nd alternate's email address

持久财务授权书

我的姓名是 _____。

我的出生日期_____。

1. **代理人。**我选择（*姓名*）

   _____，

   作为我的代理人，全权管理我的财务。

   ☐ **后备代理人。**如果上述代理人无法或不愿执行授权，我选择（*姓名*）_____
   作为我的代理人，全权管理我的财务。

   ☐ **第 2 名候补代理人。**如果上述代理人和候补代理人无法或不愿执行授权，我选择（*姓名*）

   _____
   作为我的代理人，全权管理本人财务。

2. **我的权利。**只要我仍有能力，我就会保留自行做出财务决定的权利。

3. **持久性。**假如我生病或受伤，而且无法自行做出决定，我的代理人可以使用这份授权文件管理我的财务。我的残疾状态不会影响本授权书的效力。

4. **开始日期。**本授权书生效日期：（请勾选一项）

   ☐ 立即生效

   ☐ 仅在我的医疗服务提供者签署信函，表明我无法自行做出决定时。

5. **失效日期。**如果我撤销该授权或者去世，则本授权书失效。如果我的代理人是配偶或同居伴侣，则其中任何一方在法庭上提出离婚时，本授权书即失效。

Durable Power of Attorney for Finances

My name is _____.

My date of birth is _____.

Agent. I choose (*name*) _____ as my Agent with full authority to manage my finances.

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

_____
as my Agent with full authority to manage my finances.

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 finances.

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

Durable. My Agent can use this power of attorney to manage my finances 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: (check one)

Immediately

Only if my medical provider signs a letter saying I cannot make decisions for myself.

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. **撤销。**我撤销我过去签署的任何财务授权书文件。我知悉我可以随时通过向我的代理人发出书面撤销通知来撤销此授权。

Revocation. I revoke any power of attorney for finances 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. **权力。**我的代理人应获得全面权力和授权，以充分且有效地执行本人可以进行的任何操作，包括但不限于：

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:

- ✓ 向任何金融机构中我名下的任何账户进行存款和付款 — Make deposits to, and payments from, any account in my name in any financial institution
- ✓ 打开我名下的任何保险箱并取走其中物品 — Open and remove items from any safe deposit box in my name
- ✓ 出售、交换或转移股票、债券或其他证券所有权 — Sell, exchange, or transfer title to stocks, bonds, or other securities
- ✓ 出售、转让或抵押任何不动产或个人财产 — Sell, convey, or encumber any real or personal property
- ✓ 申请并管理政府福利，包括 Medicaid — Apply for and manage governmental benefits, including Medicaid

8. **特别权力。**我的代理人还应拥有以下权力：

Special Powers. My agent shall also have the following powers:

☐ 是 ☐ 否	将我的金钱或财产作为礼物送出	Yes / No — Give gifts of my money or property
☐ 是 ☐ 否	创建、更改或取消我的生存者财产继承权	Yes / No — Create, change, or cancel my rights of survivorship
☐ 是 ☐ 否	创建、更改或取消受益人指定	Yes / No — Create, change, or cancel beneficiary designations
☐ 是 ☐ 否	放弃我作为年金或退休计划受益人的权利	Yes / No — Give up my right to be the beneficiary of an annuity or retirement plan
☐ 是 ☐ 否	创建、更改或取消某项信託	Yes / No — Create, change, or cancel a trust
☐ 是 ☐ 否	像我一样告知受託人对信託进行分配	Yes / No — Tell a trustee to make distributions from a trust just as I could
☐ 是 ☐ 否	创建、更改或取消共同财产继承协议	Yes / No — Create, change, or cancel a community property agreement

☐ 是 ☐ 否　将本文件中所授与的权限授予其他人	Yes / No　Give authority granted in this document to someone else
9. 账目。我的代理人应保管我的准确财务记录，并在我索要时出示这些记录。	**Accounting.** My Agent shall keep accurate records of my finances and show these records to me at my request.
10. 监护人或财产保管人提名。我提名将我的代理人作为财产保管人，在需要执行财产保管程序时提请法院进行考虑。	**Nomination of Guardian or Conservator.** I nominate my Agent as the conservator for consideration by the court if conservatorship proceedings become necessary.
11. HIPAA（健康保险携带和责任法案）披露。我授权我的医疗服务提供者向我的代理人披露受《 1996 年健康保险携带和责任法案 》（HIPAA） 管辖的所有信息。	**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.
日期：_____	← Date
▶_____	← My signature (in front of a notary)
我的签名（在公证员面前）	

Notarization (公证)

State of Washington *(Washington 州)*

County of *(所在郡)* _____

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

本文档已于（日期）___ 在我面前得到确认。

by (*name*) /*人员（姓名）* _____。

▶_____

Signature of Notary *(公证员签字)*

Notary Public for the State of Washington.

(Washington州公证员。)

My commission expires *(公证职责截止日期)*

_____