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**Author**

Northwest Justice Project

**Last Review Date**

October 17, 2024

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# Durable Power of Attorney for Health Care

My name is \_\_\_\_\_. My date of birth is \_\_\_\_\_.

1. **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.
2. **My Rights.** I keep the right to make health care decisions for myself if I am capable.
3. **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.
4. **Start Date.** This power of attorney is effective on the day I sign it.
5. **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. **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. **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:
  - ✓ Make health care decisions and give informed consent to my health care
  - ✓ Refuse and withdraw consent to my health care
  - ✓ Employ and discharge my health care providers
  - ✓ Apply for and consent to my admission to a medical, nursing, residential, or other similar facility that is **not** a mental health treatment facility
  - ✓ Serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended
  - ✓ Visit me at any hospital or other medical facility where I reside or receive treatment

8. **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. **Mental Health Treatment.** Unless I give my Agent power of attorney for mental health care **and** I have a Mental Health Advance Directive that specifically consents to these things:
- ✓ 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. **Accounting.** My Agent shall keep accurate records of my financial affairs and show these records to me at my request.
11. **Nomination of Guardian.** I nominate my Agent as my guardian for consideration by the court if guardianship proceedings become necessary.
12. **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.

I am signing of my own free will for the purposes stated in this document.

► \_\_\_\_\_  
My signature (*in front of a notary or witnesses*)                      Date

**Notarization (preferred)**

State of Washington

County of \_\_\_\_\_

This document was acknowledged before me on (*date*) \_\_\_\_\_  
by (*name*) \_\_\_\_\_.

► \_\_\_\_\_  
Signature of Notary  
Notary Public for the State of Washington.  
My commission expires \_\_\_\_\_.

### 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: \_\_\_\_\_

**Durable Power of Attorney for Health Care**  
**Attachment: Contact Info**

**My information**

My name \_\_\_\_\_

My date of birth \_\_\_\_\_

My phone number \_\_\_\_\_

My email address \_\_\_\_\_

My mailing address \_\_\_\_\_

My primary care medical provider \_\_\_\_\_

**Power of attorney**

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

**My health care agent**

Agent’s name \_\_\_\_\_

Agent’s relationship to me (Examples: friend, partner, spouse, sister, etc.) \_\_\_\_\_

Agent’s phone number \_\_\_\_\_

Agent’s email address \_\_\_\_\_

**My alternate health care agent (if any)**

Alternate’s agent’s name \_\_\_\_\_

Alternate agent’s relationship to me (friend, partner, spouse, sister, etc.) \_\_\_\_\_

Alternate agent’s phone number \_\_\_\_\_

Alternate agent’s email address \_\_\_\_\_

**My 2nd alternate health care agent (if any)**

2nd alternate’s name \_\_\_\_\_

2nd alternate’s relationship to me (friend, partner, spouse, sister, etc.) \_\_\_\_\_

2nd alternate’s phone number \_\_\_\_\_

2nd alternate’s email address \_\_\_\_\_

# Durable Power of Attorney for Finances

My name is \_\_\_\_\_. My date of birth is \_\_\_\_\_.

1. **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.
2. **My Rights.** I keep the right to make financial decisions for myself if I am capable.
3. **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.
4. **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.
5. **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. **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. **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:
  - ✓ Make deposits to, and payments from, any account in my name in any financial institution
  - ✓ Open and remove items from any safe deposit box in my name
  - ✓ Sell, exchange, or transfer title to stocks, bonds, or other securities
  - ✓ Sell, convey, or encumber any real or personal property
  - ✓ Apply for and manage governmental benefits, including Medicaid
8. **Special Powers.** My agent shall also have the following powers:
  - ☐ Yes ☐ No – Give gifts of my money or property



- ☐ Yes ☐ No – Create, change, or cancel my rights of survivorship
- ☐ Yes ☐ No – Create, change, or cancel beneficiary designations
- ☐ Yes ☐ No – Give up my right to be the beneficiary of an annuity or retirement plan
- ☐ Yes ☐ No – Create, change, or cancel a trust
- ☐ Yes ☐ No – Tell a trustee to make distributions from a trust just as I could
- ☐ Yes ☐ No – Create, change, or cancel a community property agreement
- ☐ Yes ☐ No – Give authority granted in this document to someone else

**9. Accounting.** My Agent shall keep accurate records of my finances and show these records to me at my request.

**10. Nomination of Conservator.** I nominate my Agent as the conservator for consideration by the court if conservatorship proceedings become necessary.

**11. 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.

I am signing of my own free will for the purposes stated in this document.



My signature (*in front of a notary*) \_\_\_\_\_

\_\_\_\_\_ Date

### Notarization (preferred)

State of Washington

County of \_\_\_\_\_

This document was acknowledged before me on (*date*) \_\_\_\_\_

by (*name*) \_\_\_\_\_.



Signature of Notary

Notary Public for the State of Washington.

My commission expires \_\_\_\_\_.