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DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. **Agent.** In the event that my attending physician or their designee determines that I am not capable of giving informed consent to health care, I _____, designate and appoint _____ as my attorney-in-fact (Health Care Agent).

2. **Alternate Agent (optional).** If the above-named Health Care Agent is unable or unwilling to act or not reasonably available, I designate and appoint _____ as my alternate attorney-in-fact (alternate Health Care Agent). **(Optional)** If the above-named alternate Health Care Agent is unable or unwilling to act or not reasonably available, I designate and appoint _____ as my alternate attorney-in-fact (alternate Health Care Agent).

3. **Authority of Health Care Agent.** My Health Care Agent is authorized to make decisions about my health care treatment that I am otherwise not able to make. This includes but is not limited to consent to initiate, continue, discontinue, or refuse medical care and treatment, as well as healthcare coordination. This includes artificial nutrition or hydration, surgical procedures and the withholding or withdrawal of life sustaining treatments. If I have executed an advance directive or living will, I authorize and direct my Health Care Agent to follow these directions. If I have not stated any wishes or desires, my Health Care Agent should act in my best interest.

4. **My Rights.** I keep the right to make health care decisions for myself as long as I am capable. This power of attorney will become effective only when I am unable to make health care decisions for myself as determined by my attending physician or their designee. My designated Health Care Agent’s power will cease if and when I regain my capacity to make health care decisions as determined by my attending physician or their designee.

5. **Durable.** I intend to create a durable health care power of attorney. This power of attorney shall not be affected by my disability.

6. **End Date.** This health care power of attorney will terminate if I revoke it or when I die.

7. **Revocation.** I hereby revoke any prior grants of durable power of attorney for health care I have signed in the past. Should such prior durable power of attorney for health care exist in a document containing other grants of powers of attorney, I intend this document to revoke only the health care grants of power.

Signed _____ Date _____

FORM CONTINUES ON NEXT PAGE

PLACE PATIENT LABEL HERE

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NOTARIZATION

State of Washington

County of _____

I certify that I know or have satisfactory evidence that the Grantor, _____, is the person who appeared before me, signed above, and acknowledged that the signing was done freely and voluntarily for the purposes mentioned in this instrument.

SUBSCRIBED and SWORN to before me on _____

SIGNATURE OF NOTARY _____

PRINT NAME OF NOTARY _____

NOTARY PUBLIC for the State of Washington

My commission expires: _____

WITNESSES

In lieu of notarization, this document may be witnessed by two competent persons who are NOT:

- Home care providers for the principal;
- Care providers at an adult family home or long-term care facility in which the principal resides; or
- Related to the principal or any designated Health Care Agent by blood, marriage, or state registered domestic partnership.

Witness Name _____ Signature _____

Witness Name _____ Signature _____

Contact Information (Optional)

Agent Name:	Agent Telephone Number:	Other Contact Information:
Alternate Agent Name:	Alternate Agent Telephone Number:	Other Contact Information:

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If you are unable to make informed health care decisions for yourself, you can designate others to make those decisions for you. In order of priority, Washington state law ([RCW 7.70.065](#)) gives this authority to:

1. A court-appointed guardian;
2. The person you granted a durable power of attorney for health care decisions;
3. Your spouse or state registered domestic partner;
4. Your children who are over the age of eighteen, if all agree on a decision;
5. Your parents, if all agree on a decision;
6. Your adult brothers and sisters, if all agree on a decision;
7. Your adult grandchildren, if all agree on a decision (effective July 28, 2019);
8. Your adult nieces and nephews, if all agree on a decision (effective July 28, 2019);
9. Your adult aunts and uncles, if all agree on a decision (effective July 28, 2019); then
10. At your physician's discretion, an adult who has exhibited concern for you, is familiar with your values, is reasonably available to make health care decisions, is not your physician or an employee of your physician, is not the owner, administrator, or employee of health care facility, nursing home, or long-term care facility where you reside or receive care; or a person who receives compensation to provide you with care, and who executes a declaration attesting to all of these conditions.

A durable power of attorney (DPOA) for health care is the legal document that allows you to choose the person you would like to make health care decisions for you. It can be any adult you trust, including a close friend or other relative. Your physician or their employees, or the owners, administrators or employees of a health care or long-term care facility where you receive care cannot be appointed unless they are related to you.

The person you appoint as your health care agent must make decisions consistent with your wishes, or if they are unknown, in your best interest. This may include decisions to initiate, continue, discontinue or refuse medical care and treatment. This includes artificial nutrition or hydration, surgical procedures, and the withholding or withdrawal of life sustaining treatments. It is important that you discuss your wishes with the person(s) you designate as your agent. You may want to complete an Advance Directive for Health Care to memorialize these discussions and your preferences. Your provider can give you more information about that form.

A DPOA for health care may take many forms. The attached form is a sample which, when properly completed, becomes effective only when you are unable to make your own health care decisions. You may

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choose to use this DPOA form or any other legally sufficient form you wish. Washington State requires this directive to be notarized or witnessed by two different witnesses. Although we provide this for your convenience, we cannot assure the validity of the form.

This is not intended as a substitute for legal advice. Should you have any questions about DPOA for health care, including completing this form, please contact an attorney. If you would like assistance in locating an attorney, including low cost or legal aid options, you can contact the King County Bar Association at (206) 267-7010. You may also visit www.washingtonlawhelp.org for free legal information and self-help materials.

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