Advance Medical Directive

Prepared exclusively for

_____

Copies of this document to be sent to:

Health Care Directive
of

_____

[My Name]

As a person with capacity, I willfully and voluntarily execute this Health Care Directive. In the absence of my ability to give directions regarding the use of life sustaining treatment, it is my intention that this directive shall be honored by my family and all medical providers as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences of such refusal. If I have appointed another person to make health care decisions for me, whether through a durable power of attorney or otherwise, then I request that my agent be guided by my desires as expressed in this directive or as otherwise communicated to my agent. It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

1. Withhold and Withdraw Treatment. If at any time I should be diagnosed in writing to be in a terminal condition by my physician, or in a permanent unconscious condition by two physicians, and where the application of life sustaining treatment would serve only artificially to prolong the process of my dying, I direct that the following treatment be withheld or withdrawn: (*initial the choices that apply*)

   ____ Artificial nutrition.

   ____ Artificial hydration.

   ____ Artificial respiration.

   ____ Cardiopulmonary Resuscitation (CPR) , including artificial ventilation, heart regulating drugs, diuretics, stimulants, or any other treatment for heart failure.

   ____ Surgery to prolong my life or keep me alive.

   ____ Blood dialysis or filtration for lost kidney function.

   ____ Blood transfusion to replace lost or contaminated blood.

   ____ Medication used to prolong life, not for controlling pain.

   ____ Any other medical treatment used to prolong my life or keep me alive.

2. Comfort Care and Pain Medication. If at any time I should be diagnosed in writing to be in a terminal condition by my physician, or in a permanent unconscious condition by two physicians, I want treatment to relieve my pain and symptoms and make me comfortable if I appear to be in pain or experiencing other signs of discomfort, even if my physicians or other medical providers believe this might unintentionally hasten my death.

3. Health Care Institutions – Refusal to Honor My Advance Directive. If I am a patient at a health care institution whose policy is to decline to follow advance directives that conflict with certain religious or other beliefs when this document comes into effect, I direct that my consent to admission shall not constitute implied consent to procedures or courses of treatment that conflict with this advance directive. Moreover, if a health care institution declines to follow my wishes set out in the advance directive when this document comes into effect, I direct that I be transferred as soon as possible to a hospital, nursing home, or other institution that will honor the instructions provided in this document.

4. Changes and Revocation. I understand that, before I sign this directive, I can add to or delete from or otherwise change the wording of this directive. I further understand that at any time I may revoke this directive entirely or execute a new directive with different provisions. Any changes must be consistent with Washington State law or federal constitutional law to be legally valid.

5. Pregnancy. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive: (*initial the choice that applies*)

   ____ shall still have full force and effect during the course of my pregnancy.

   ____ shall have no force or effect during the course of my pregnancy.

6. Additional Directions: I make the following additional directions regarding my care:

I have signed this document in the presence of two (2) witnesses <u>OR</u> a notary public.

_____ _____

My Signature Date

NOTICE: This document must be signed with either two (2) witnesses or a notary public.

Two (2) Witnesses

_____	_____
Witness 1 Signature	Witness 2 Signature
_____	_____
Name	Name
_____	_____
Address	Address

Notarization

State of Washington

County of _____

I certify that I know or have satisfactory evidence that_____, 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 _____

Durable Power of Attorney for Health Care
for

_____

[My Name]

1. **Agent.** I choose _____as my Agent with full authority to manage my health care.

2. **Alternate.** If _____is unable or unwilling to act, I choose _____as my Agent with full authority to manage my health care.

3. **My Rights.** I keep the right to make health care decisions for myself as long as I am capable.

4. **Durable.** My Agent can still use this power of attorney document to manage my affairs even if I become sick or injured and cannot make decisions for myself. This power of attorney shall not be affected by my disability.

5. **Start Date.** This power of attorney document is effective on the day I sign it in front of a notary public.

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

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

8. **Powers.** My Agent shall have full power and authority to do anything as fully and effectively as I could do myself, including 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, and to visit me at any hospital or other medical facility where I reside or receive treatment

9. **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. **No Power to Agree to Binding Pre-Dispute Arbitration.** I recognize that some long-term-care providers will ask me or my Agent to sign a binding pre-dispute arbitration agreement. These agreements limit my right to sue the provider before any injury or dispute occurs. I think these agreements are unfair and unacceptable. Therefore, my agent does not have the power to agree to pre-dispute binding

arbitration or any other process involving my person or property that limits my right to a jury, to sue for money, or to join a class action.

11. Accounting. My Agent shall keep accurate records of my financial affairs and show these records to me at my request.

12. Nomination of Guardian. I nominate my Agent as the guardian of my person for consideration by the court if guardianship proceedings become necessary.

13. 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.

_____ _____

My Signature Date

NOTICE: This document must be signed with either two (2) witnesses or a notary public.

Witness 1	Witness 2
_____	_____
Signature	Signature
_____	_____
Name	Name
_____	_____
Address	Address

Notarization

State of Washington
County of _____

I certify that I know or have satisfactory evidence that_____, 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 _____.

Power of Attorney for Health Care

I designate the following individual as my agent to make health care decisions for me:

MY ADVANCED MEDICAL DIRECTIVE CARD

Name:

Exp.:

ID#:

EMERGENCY CONTACT

Cell:

Home:

Work:

Allergies:

Conditions: