WASHINGTON HEALTH CARE DIRECTIVE

(LIVING WILL / HEALTH CARE POWER OF ATTORNEY)

OF

John Doe

Directive made this _____day of ________________, 20_____.

I, John Doe, being of sound mind and disposing mind and memory, do hereby make and declare this to be my health care directive, thereby revoking and making null and void any and all other health care directives, living wills, and health care powers of attorney previously made by me.

[This section will appear if you select living will and will vary depending on your choices in regards to life support.]

1. LIVING WILL

[This section will appear if you elect to be kept on life support.]

A. I willfully and voluntarily make known my desire to prolong my life as long as reasonably possible within the limits of generally accepted health care standards.

[This section will appear if you elect to not be kept on life support and will vary depending on your choices.]

A. I, having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

1. If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this document that a terminal condition means an incurable and irreversible condition caused
by injury, disease, or illness, that would within reasonable medical
judgment cause death within a reasonable period of time in accordance
with accepted medical standards, and where the application of life-
sustaining treatment would serve only to prolong the process of dying. I
further understand in using this document that a permanent unconscious
condition means an incurable and irreversible condition in which I am
medically assessed within reasonable medical judgment as having no
reasonable probability of recovery from an irreversible coma or a
persistent vegetative state.

2. In the absence of my ability to give directions regarding the use of such
life-sustaining treatment, it is my intention that this directive shall be
honored by my family and physician(s) as the final expression of my legal
right to refuse medical or surgical treatment and I accept the consequences
of such refusal. If another person is appointed to make these decisions for
me, whether through this document or otherwise, I request that the
person be guided by this directive and any other clear expressions of my
desires.

3. If I am diagnosed to be in a terminal condition or in a permanent
unconscious condition: I DO want to have artificially provided nutrition
and hydration.

B. I desire to receive treatment for comfort or to alleviate pain, except: This
section is reserved for any limitations you place on the use of pain medication.

[This section will appear if you write additional health care instructions.]

C. I further direct that: This section is reserved for any additional health care
instructions you provide.

[This section varies depending upon your choices regarding organ donation.]

II. ANATOMICAL GIFTS

I hereby authorize the making of anatomical gifts of the following parts of my
body for the following purposes:

<table>
<thead>
<tr>
<th>Gift</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>All organs and parts.</td>
<td>Medical purposes, education, and research.</td>
</tr>
</tbody>
</table>
III. **POWER OF ATTORNEY FOR HEALTH CARE**

A. In the event that I have been determined by two physicians to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my agent for health care decisions:

   Name: Jane Doe  
   Relation: Spouse  
   Address: 123 Main Street  
   Redmond, Washington 98053  
   Phone: (323) 962-8600  
   Alt. Phone: (323) 962-8600  
   Email: jane@legalzoom.com

If my agent is unable or is unwilling to perform his or her duties, I designate as my alternate agent:

   Name: Amber Doe  
   Relation: Daughter  
   Address: 123 Main Street  
   Redmond, Washington 98053  
   Phone: (323) 962-8600  
   Alt. Phone: (323) 962-8600  
   Email: amber@legalzoom.com

B. I fully understand, and intend, that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of healthcare; to have access to my records necessary to make decisions or apply for benefits; and to authorize my admission to or transfer from a health care facility. I specifically give my agent the power and authority to provide, withdraw, or withhold consent to the provision of life-prolonging procedures on my behalf; and to execute all documents, waivers and releases related to any of the foregoing and the powers set forth in the previous sentence. My agent must act consistently with my desires as outlined in my living will, if any.
Notwithstanding the foregoing, the authority of my surrogate is limited as follows: This section is reserved for any limitations that you place on your agent’s authority.

C. I authorize my agent to direct the disposition of my remains.

D. I authorize my agent to consent to an autopsy of my remains.

E. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any similar state laws, and exclusively for the purpose of making a determination of my incapacitation or inability to direct my own health care decisions and obtaining a physician affidavit of such, I authorize any health care provider to disclose to the person named herein as my health care agent or alternate health care agent, as applicable, any pertinent individually identifiable health information sufficient to determine whether I am by reason of illness or mental or physical disability incapacitated or incapable of directing my own health care decisions. In exercising such authority, my health care agent shall constitute my “personal representative” as defined by HIPAA.

Upon the determination of my incapacitation or incapability to direct my own health care decisions, I intend for the person named herein as my health care agent or alternate health care agent, as applicable, to be treated as my “personal representative” under HIPAA and any similar state law, and as such to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records.

IV. GENERAL PROVISIONS

A. I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

B. I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.
C. 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.

D. It is my intent that this document be legally binding and effective. If the law does not recognize the legal validity of this document, it is my intention that this document be taken as a formal declaration of my intentions concerning all of the above provisions. Copies of this document have the same effect as the original.

E. All persons or entities that in good faith endeavor to carry out the provisions of this document shall not be liable to me, my estate, or my heirs, for any damages or claims arising because of their actions or inactions based on this document. My estate shall indemnify and hold them harmless.
IN WITNESS WHEREOF, I have executed this document on the date below:

____________________________________
Signature of John Doe

Dated: _______________________, 20___

123 Main Street
Redmond, Washington 98053
WITNESS DECLARATIONS

Under penalty of perjury, each of the undersigned declares that: (1) John Doe has been personally known to me (or that the individual’s identity was proven to me by convincing evidence), and I believe him or her to be of sound mind and not under duress, fraud or undue influence; (2) John Doe signed or acknowledged this document in my presence, and I did not sign John Doe’s signature; (3) I am not related to John Doe by blood, adoption, or marriage; (4) I am not entitled to any part of John Doe’s estate or directly financially responsible for his or her medical care; (5) I am competent and at least eighteen years of age; (6) I am not John Doe’s doctor or physician, or an employee of John Doe’s doctor or physician; and (7) I am not the operator or an employee of a community care facility or a residential care facility for the elderly.

Date: ____________________________
Signature: ________________________
Print Name: ______________________
Address: _________________________

Date: ____________________________
Signature: ________________________
Print Name: ______________________
Address: _________________________
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