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Legal Forms & Services

FirstName LastName
WASHINGTON HEALTH CARE DIRECTIVE & LIVING WILL

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive & Living Will in Washington

After printing your document, you will need to finalize it. Below are the steps:

Option 1: Witnesses Only

1. Print out your document
2. Review, initial, sign, and date in front of two witnesses
3. Have witnesses sign and date
4. Keep document in a safe place

Option 2: Notary Only

1. Print out your document
2. Review, initial, sign, and date in front of a notary
3. Have notary sign and date
4. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to health care directives and living wills, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive and living will. Review your state's laws on witness requirements for health care directives and living wills.

HEALTH CARE DIRECTIVE & LIVING WILL

FOR

FIRSTNAME LASTNAME

This document includes the following:

Directive instructing the withholding or withdrawal of life-sustaining treatment to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

Power of attorney for health care designating a health care agent to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my health care agent should act in my best interest.

HEALTH CARE DIRECTIVE

Directive made this __ day of _____, _____

I, FirstName LastName, 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

(a) 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 form 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 form 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.

(b) 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 a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):

☐ I DO want to have artificially provided nutrition and hydration.

_____☑ I DO NOT want to have artificially provided nutrition and hydration.

(d) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

(e) 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.

(f) 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.

(g) 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.

POWER OF ATTORNEY FOR HEALTH CARE

I, FirstName LastName, appoint the following individual as my health care agent to make health care decisions on my behalf if I become incapacitated and am unable to make or communicate health care decisions for myself:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, Washington 12345

Phone: (555) 555-5555

Email: name@email.com

If my first choice is not willing, able, or reasonably available, I name the following individual as my alternate health care agent to make health care decisions for me:

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, Washington 12345

Phone: (555) 555-5555

Email: name@email.com

My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest. Generally, my agent's authority includes the following:

- Access my health care information and communicate with my health care providers
- Consent or refuse to consent to care, treatment, service, or procedures
- Select or discharge health care providers
- Approve or disapprove proposed tests, surgical procedures, and medication
- Direct the provision, withholding, or withdrawal of life-prolonging treatment, including artificial nutrition and hydration and pain relief medication and treatment
- Make an anatomical gift following my death

Limitations on Health Care Agent's Authority: I do not wish to limit the authority of my health care agent at this time.

Additional Instructions: No blood transfusions.

SIGNATURES

This document must be signed and dated by me. It also must either be verified by two witnesses (Option 1) OR a notary public (Option 2). It must be signed and dated when it is witnessed or verified.

I, FirstName LastName, sign this directive voluntarily and declare I am capable of understanding the instructions I have given and the choices I have made therein. I understand that I may revoke this directive at any time prior to my incapacity.

My Signature: _____

Date signed: _____

If I cannot sign my name, I ask the below named person to sign for me.

In my presence on _____ (date), FirstName LastName (name) orally directed that I sign this document on his/her/their behalf. I certify the following:

- This acknowledgment is obtained in accordance with Revised Code of Washington § 64.08.100.

Signature: _____

Printed Name:_____

TWO WITNESSES (OPTION 1)

Witness One. In my presence on _____ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- I am not related to the principal by blood or marriage and not entitled to any portion of the estate of the principal upon principal's decease under any will of principal or codicil or by operation of law
- I am not the attending physician, an employee of the attending physician or a health facility in which the principal is a patient
- I do not have a claim against any portion of the estate of the principal upon the principal's decease
- I am not a home care provider for the principal nor care provider at an adult family home or long-term care facility in which the principal resides
- I am not related to the principal or agent by blood, marriage, or state registered domestic partnership

Witness One Signature: _____

Witness One Printed Name: _____

Witness One Address: _____

_____

Witness One Phone: _____

Witness Two. In my presence on _____ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf. I certify the following:

- I am not related to the principal by blood or marriage and not entitled to any portion of the estate of the principal upon principal's decease under any will of principal or codicil or by operation of law
- I am not the attending physician, an employee of the attending physician or a health facility in which the principal is a patient
- I do not have a claim against any portion of the estate of the principal upon the principal's decease
- I am not a home care provider for the principal nor care provider at an adult family home or long-term care facility in which the principal resides
- I am not related to the principal or agent by blood, marriage, or state registered domestic partnership

Witness Two Signature: _____

Witness Two Printed Name: _____

Witness Two Address: _____

_____

Witness Two Phone: _____

OR

NOTARY PUBLIC (OPTION 2)

In my presence on _____ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf.

Notary Public Signature: _____

Commission Expiration Date: _____

Authorization for Release of Health Care Information

This form authorizes the release of confidential information pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

I, FirstName LastName, authorize (**insert the name of a medical entity or health care provider)** _____ to release

(put a check mark √ next to one of the three options below)

___ All my health information and medical records

___ My health information and medical records from **(insert start date)** _____ to **(insert end date)** _____

___ My health information and medical records as follows: **(describe how you would like the records released)**

_____
_____
_____
_____

to: **(insert name and address of recipient of this release)**

Name:_____

Address: _____

_____

_____ ("Recipient").

This authorization is valid

(put a check mark √ next to one of the three options below)

___ from **(insert start date)** _____ to **(insert end date)** _____.

___ upon **(describe the event that would trigger the release of these records)** _____.

___ effective immediately until revoked by me.

The purpose of this disclosure is at my request.

I understand the following:

- I am voluntarily authorizing the disclosure of the above information.

- Information in my medical records may include information about sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health services, and alcohol and drug abuse treatment.
- I have the right to revoke this authorization at any time in writing.
- My revocation will not apply to any information that has already been released by following this authorization.
- Information disclosed to the Recipient may be disclosed by the Recipient and no longer be protected by Federal confidentiality rules.

_____ _____

FirstName LastName Date

111 Street Address, City, Washington 12345