RCW 71.32.260 Form. The directive shall be in substantially the following form:

Mental Health Advance Directive of (client name)
With Appointment of (agent name) as
Agent for Mental Health Decisions

PART I.
STATEMENT OF INTENT TO CREATE A
MENTAL HEALTH ADVANCE DIRECTIVE

I, (Client name), being a person with capacity, willfully and voluntarily execute this mental health advance directive so that my choices regarding my mental health care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my mental health care.

PART II.
MY CARE NEEDS – WHAT WORKS FOR ME

In order to assist in carrying out my directive I would like my providers and my agent to know the following information:
I have been diagnosed with (client illnesses both mental health and physical diagnoses) for which I take (list medications).
I am also on the following other medications: (list any other medications for other conditions).
The best treatment method for my illness is (give general overview of what works best for client).
I have/do not have a history of substance abuse. My preferences and treatment options around medication management related to substance abuse are:

PART III.
WHEN THIS DIRECTIVE IS EFFECTIVE
(*You must complete this part for your directive to be valid.)*

I intend that this directive become effective (YOU MUST CHOOSE ONLY ONE):
. . . . . . Immediately upon my signing of this directive.
. . . . . . If I become incapacitated.
. . . . . . When the following circumstances, symptoms, or behaviors occur:

PART IV.
DURATION OF THIS DIRECTIVE
(You must complete this part for your directive to be valid.)

I want this directive to (YOU MUST CHOOSE ONLY ONE):
. . . . . . Remain valid and in effect for an indefinite period of time.
. . . . . . Automatically expire . . . . . . years from the date it was created.

PART V.
WHEN I MAY REVOKE THIS DIRECTIVE
(You must complete this part for this directive to be valid.)

I intend that I be able to revoke this directive (YOU MUST CHOOSE ONLY ONE):
. . . . . . Only when I have capacity.
I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I may receive treatment that I specify in this directive, even if I object at the time.
. . . . . . Even if I am incapacitated.
I understand that choosing this option means that I may revoke this directive even if I am incapacitated. I further understand that if I choose this option and revoke this directive while I am incapacitated I may not receive treatment that I specify in this directive, even if I want the treatment.

PART VI.
PREFERENCES AND INSTRUCTIONS ABOUT TREATMENT, FACILITIES, AND PHYSICIANS, PHYSICIAN ASSISTANTS, OR *ADVANCED REGISTERED NURSE PRACTITIONERS

A. Preferences and Instructions About Physician(s), Physician Assistant(s), or *Advanced Registered Nurse Practitioner(s) to be Involved in My Treatment

I would like the physician(s), physician assistant(s), or *advanced registered nurse practitioner(s) named below to be involved in my treatment decisions:
I do not wish to be treated by

B. Preferences and Instructions About Other Providers

I am receiving other treatment or care from providers who I feel have an impact on my mental health care. I would like the following treatment provider(s) to be contacted when this directive is effective:

C. Preferences and Instructions About Medications for Psychiatric Treatment (check all that apply)
. . . . . . I consent, and authorize my agent (if appointed) to consent, to the following medications:
. . . . . . I do not consent, and I do not authorize my agent (if appointed) to consent, to the administration of the following medications:
. . . . . . I am willing to take the medications excluded above if my only reason for excluding them is the side effects which include:
and these side effects can be eliminated by dosage adjustment or other means
. . . . . . I am willing to try any other medication the hospital doctor, physician assistant, or *advanced registered nurse practitioner recommends.
. . . . . . I am willing to try any other medications my outpatient doctor, physician assistant, or *advanced registered nurse practitioner recommends.
. . . . . . I do not want to try any other medications.
Medication Allergies.
I have allergies to, or severe side effects from, the following:
Other Medication Preferences or Instructions
. . . . . . I have the following other preferences or instructions about medications:

D. Preferences and Instructions About Hospitalization and Alternatives
(check all that apply and, if desired, rank "1" for first choice, "2" for second choice, and so on)
. . . . . . In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I prefer to receive this care in programs/facilities designed as alternatives to psychiatric hospitalizations.
. . . . . . I would also like the interventions below to be tried before hospitalization is considered:
. . . . . . Calling someone or having someone call me when needed.
Name:. . . . . Telephone/text:. . . . . Email:. . . . .
. . . . . . Staying overnight with someone
Name:. . . . . Telephone/text:. . . . . Email:. . . . .
. . . . . . Having a mental health service provider come to see me.
. . . . . . Going to a crisis triage center or emergency room.
. . . . . . Staying overnight at a crisis respite (temporary) bed.
. . . . . . Seeing a service provider for help with psychiatric medications.
. . . . . . Other, specify:

Authority to Consent to Inpatient Treatment
I consent, and authorize my agent (if appointed) to consent, to voluntary admission to inpatient mental health treatment for ...... days (not to exceed 14 days).

(Sign one): . . . .

. . . . . . If deemed appropriate by my agent (if appointed) and treating physician, physician assistant, or *advanced registered nurse practitioner

. . . .
(Signature)

Or

. . . . . . Under the following circumstances (specify symptoms, behaviors, or circumstances that indicate the need for hospitalization)

. . . .
(Signature)

. . . . . . I do not consent, or authorize my agent (if appointed) to consent, to inpatient treatment

. . . .
(Signature)

Hospital Preferences and Instructions
If hospitalization is required, I prefer the following hospitals:
I do not consent to be admitted to the following hospitals:

E. Preferences and Instructions About Preemergency
I would like the interventions below to be tried before use of seclusion or restraint is considered (check all that apply):
. . . . . . "Talk me down" one-on-one
. . . . . . More medication
. . . . . . Time out/privacy
. . . . . . Show of authority/force
. . . . . . Shift my attention to something else
. . . . . . Set firm limits on my behavior
. . . . . . Help me to discuss/vent feelings
. . . . . . Decrease stimulation
. . . . . . Offer to have neutral person settle dispute
. . . . . . Other:

F. Preferences and Instructions About Seclusion, Restraint, and Emergency Medications
If it is determined that I am engaging in behavior that requires seclusion, physical restraint, and/or emergency use of medication, I prefer these interventions in the order I have chosen (choose "1" for first choice, "2" for second choice, and so on):
. . . . . . Seclusion
. . . . . . Seclusion and physical restraint (combined)
. . . . . . Medication by injection
. . . . . . Medication in pill or liquid form
In the event that my attending physician, physician assistant, or *advanced registered nurse practitioner decides to use medication in response to an emergency situation after due consideration of my preferences and instructions for emergency treatments stated above, I expect the choice of medication to reflect any preferences and instructions I have expressed in Part VI C. of this form. The preferences and instructions I express in this section regarding medication in emergency situations do not constitute consent to use of the medication for nonemergency treatment.

G. Preferences and Instructions About Electroconvulsive Therapy
(ECT or Shock Therapy)
My wishes regarding electroconvulsive therapy are (sign one):
. . . . . .I do not consent, nor authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

. . . .
(Signature)

. . . . . . I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy

. . . .
(Signature)

. . . . . . I consent, and authorize my agent (if appointed) to consent, to the administration of electroconvulsive therapy, but only under the following conditions:

. . . .
(Signature)

H. Preferences and Instructions About Who is Permitted to Visit
If I have been admitted to a mental health treatment facility, the following people are not permitted to visit me there:

Name: . . . .

Name: . . . .

I understand that persons not listed above may be permitted to visit me.

I. Additional Instructions About My Mental Health Care
Other instructions about my mental health care:
In case of emergency, please contact:

Name: . . . .
Address: . . . .
Work telephone: . . . .
Home telephone: . . . .
Physician, physician assistant, or *advanced registered nurse practitioner: . . . .
Address: . . . .
Telephone: . . . .
Email: . . . .

The following may help me to avoid a hospitalization:
I generally react to being hospitalized as follows:
Staff of the hospital or crisis unit can help me by doing the following:

J. Refusal of Treatment
I do not consent to any mental health treatment.

. . . .
(Signature)

PART VII.
DURABLE POWER OF ATTORNEY (APPOINTMENT OF MY AGENT)

(*Fill out this part only if you wish to appoint an agent or nominate a guardian.*)

I authorize an agent to make mental health treatment decisions on my behalf. The authority granted to my agent includes the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service, or procedure, consistent with any instructions and/or limitations I have set forth in this directive. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document **and my agent does not otherwise know my wishes**, I authorize my agent to make the decision that my agent determines is in my best interest. This agency shall not be affected by my incapacity. Unless I state otherwise in this durable power of attorney, I may revoke it unless prohibited by other state law.

HIPAA Release Authority. In addition to the other powers granted by this document, I grant to my Attorney-in-Fact the power and authority to serve as my personal representative for all purposes under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended from time to time, and its regulations. My Attorney-in-Fact will serve as my "HIPAA personal representative" and will exercise this authority at any time that my Attorney-in-Fact is exercising authority under this document.

A. Designation of an Agent

Name: . . . . Address: . . . .

Work phone: . . . . Home/cell phone: . . . .

Relationship: . . . . Email: . . . .

B. Designation of Alternate Agent

If the person named above is unavailable, unable, or refuses to serve as my agent, or I revoke that person's authority to serve as my agent, I hereby appoint the following person as my alternate agent and request that this person be notified immediately when this directive becomes effective or when my original agent is no longer my agent:

Name: . . . . Address: . . . .

Work phone: . . . . Home phone: . . . .

Relationship: . . . . Email: . . . .

C. Limitations on My Agent's Authority

I do not grant my agent the authority to consent on my behalf to the following:

D. Limitations on My Ability to Revoke this Durable Power of Attorney

I choose to limit my ability to revoke this durable power of attorney as follows:

E. Preference as to Court-Appointed Guardian

In the event a court appoints a guardian who will make decisions regarding my mental health treatment, I **nominate** my then-serving agent (or name someone else) **as my guardian**:

Name and contact information (if someone other than agent or alternate):

The appointment of a guardian of my estate or my person or any other decision maker shall not give the guardian or decision maker the power to revoke, suspend, or terminate this directive or the powers of my agent, except as authorized by law.

PART VIII.
OTHER DOCUMENTS

(*Initial all that apply*)

I have executed the following documents that include the power to make decisions regarding health care services for myself:

. . . . . . Health care power of attorney (chapter 11.125 RCW)

. . . . . . "Living will" (Health care directive; chapter 70.122 RCW)

. . . . . . I have appointed more than one agent. I understand that the most recently appointed agent controls except as stated below:

PART IX.
NOTIFICATION OF OTHERS AND CARE OF PERSONAL AFFAIRS

(*Fill out this part only if you wish to provide nontreatment instructions.*)

I understand the preferences and instructions in this part are **NOT** the responsibility of my treatment provider and that no treatment provider is required to act on them.

A. Who Should Be Notified

I desire my agent to notify the following individuals as soon as possible if I am admitted to a mental health facility:

Name: . . . . Address: . . . .

Day telephone: . . . . Evening telephone: . . . .

Name: . . . . Address: . . . .

Day telephone: . . . . Evening telephone: . . . .

Name: . . . . Address: . . . .

Day telephone: . . . . Evening telephone: . . . .

B. Preferences or Instructions About Personal Affairs

I have the following preferences or instructions about my personal affairs (e.g., care of dependents, pets, household) if I am admitted to a mental health treatment facility:

C. Additional Preferences and Instructions:

PART X.
SIGNATURE

By signing here, I indicate that I understand the purpose and effect of this document and that I am giving my informed consent to the treatments and/or admission to which I have consented or authorized my agent to consent in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under chapter 7.70 RCW.

In witness of this, I have signed on this . . . . . . day of . . . . . ., 20. . . .
Signature: . . . .

STATE OF WASHINGTON)
) ss.
COUNTY OF . . . .)

I certify that I know or have satisfactory evidence that (client name) is the person who appeared before me, and said person acknowledged that he or she signed this Durable Power of Attorney and acknowledged it to be his or her free and voluntary act for the uses and purposes mentioned in this instrument.
SUBSCRIBED and SWORN to before me this . . . . . . day of . . . . . ., 20. . . .

. . . .
SIGNATURE OF NOTARY

. . . .
PRINT NAME OF NOTARY

NOTARY PUBLIC for the State of Washington at . . . .
My commission expires . . . .
OR have two witnesses:
Name: . . . .

This directive was signed and declared by the "Principal," to be his or her directive, in our presence who, at his or her request, have signed our names below as witnesses. We declare that, at the time of the creation of this instrument, the Principal is personally known to us, and, according to our best knowledge and belief, has capacity at this time and does not appear to be acting under duress, undue influence, or fraud. We further declare that none of us is:

(A) A person designated to make medical decisions on the principal's behalf;

(B) A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed;

(C) An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident;

(D) A person who is related by blood, marriage, or adoption to the person, or with whom the principal has a dating relationship as defined in RCW 7.105.010;

(E) An incapacitated person;

(F) A person who would benefit financially if the principal undergoes mental health treatment; or

(G) A minor.

Witness 1 Signature: . . . . Date: . . . .

Printed Name: . . . . Address: . . . .

Telephone: . . . .

Witness 2 Signature: . . . . Date: . . . .

Printed Name: . . . . Address: . . . .

Telephone: . . . .

PART XI.
RECORD OF DIRECTIVE

I have given a copy of this directive to the following persons:

Name: . . . . Address: . . . .
Day telephone: . . . . Evening telephone: . . . .
Name: . . . . Address: . . . .
Day telephone: . . . . Evening telephone: . . . .

DO NOT FILL OUT PART XII UNLESS YOU INTEND TO REVOKE
THIS DIRECTIVE IN PART OR IN WHOLE

PART XII.
REVOCATION OF THIS DIRECTIVE

(Initial any that apply):
. . . . . . I am revoking the following part(s) of this directive (specify):

Date: . . . .

. . . . . . I am revoking all of this directive.

By signing here, I indicate that I understand the purpose and effect of my revocation and that no person is bound by any revoked provision(s). I intend this revocation to be interpreted as if I had never completed the revoked provision(s).

. . . .
(Signature)

Printed Name: . . . .

DO NOT SIGN THIS PART UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN PART OR IN WHOLE

[2021 c 287 s 19; 2021 c 215 s 159. Prior: 2016 c 209 s 413; 2016 c 155 s 16; 2009 c 217 s 14; 2003 c 283 s 26.]

Reviser's note: *(1) The term "advanced registered nurse practitioner" was changed to "advanced practice registered nurse" by 2024 c 239 s 1, effective June 30, 2027.

(2) This section was amended by 2021 c 215 s 159 and by 2021 c 287 s 19, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2022 c 268; 2021 c 215: See note following RCW 7.105.900.

Short title—Application—Uniformity—Federal law application—Federal electronic signatures in global and national commerce act—Application—Dates—Effective date—2016 c 209: See RCW 11.125.010 and 11.125.900 through 11.125.903.