202406280019
06/28/2024 09:18 AM Pages: 1 of 3 Fees: $305.50
Skagit County Auditor, WA

When recorded return to:
Shirley M. Liston
7706 71st Ave NW
Gig Harbor, WA 98335

Filed for record at the request of:

CHICAGO TITLE
COMPANY OF WASHINGTON

11900 NE 1st St., Suite 110
Bellevue, WA 98005

Escrow No.: 0275014-OC

Chicago Title
620056654

DOCUMENT TITLE(S)

Durable Power of Attorney for Health Care

REFERENCE NUMBER(S) OF DOCUMENTS ASSIGNED OR RELEASED: _____

Additional reference numbers on page _____ of document

GRANTOR(S)

Shirley M. Liston

☐ Additional names on page _____ of document

GRANTEE(S)

John W. Liston

☐ Additional names on page _____ of document

ABBREVIATED LEGAL DESCRIPTION

LOT 52, COUNTRY CLUB ADDITION NO. 5, ACCORDING TO THE PLAT THEREOF RECORDED IN VOLUME 11 OF PLATS, PAGES 32 AND 33, RECORDS OF SKAGIT COUNTY, WASHINGTON. SITUATE IN THE COUNTY OF SKAGIT, STATE OF WASHINGTON.

Complete legal description is on page _____ of document

TAX PARCEL NUMBER(S)

P79377

Additional Tax Accounts are on page _____ of document

The Auditor/Recorder will rely on the information provided on this form. The staff will not read the document to verify the accuracy or completeness of the indexing information provided herein.

"I am signing below and paying an additional $50 recording fee (as provided in RCW 36.18.010 and referred to as an emergency nonstandard document), because this document does not meet margin and formatting requirements. Furthermore, I hereby understand that the recording process may cover up or otherwise obscure some part of the text of the original document as a result of this request."

_____ Signature of Requesting Party

Note to submitter: Do not sign above nor pay additional $50 fee if the document meets margin/formatting requirements

Durable Power of Attorney for Health Care for

Shirley M Linton
(My Name)

1. **Agent.** I choose John W. Linton 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.

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. **Government Benefits.** My Agent shall have full power and authority to arrange for and manage all government benefits on my behalf, including but not limited to signing and consenting to applications, contracts, ongoing eligibility review agreements, and care plans for federal and state cash, food, medical, housing, and long-term care benefits and services.

10. **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.

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 or Conservator.** I nominate my Agent as the guardian of my person for consideration by the court if guardianship and/or conservatorship 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.

3-08-2024
Date

Shirley Ann Linton
My Signature (*in front of a notary or witnesses*)

Notarization

State of Washington
County of Skagit

Signed or attested before me on (*date*) March 8th, 2024
by (*name*) Shirley Ann Linton

ALAN GARCIA
NOTARY PUBLIC
STATE OF WASHINGTON

Signature of Notary
Notary Public for the State of Washington.
My commission expires February 11, 2026

Statement of Witnesses (alternative if you can't find a notary)

On the date written above, the declarer signed this Durable Power of Attorney for Health Care in my presence. I believe the declarer is able to make health care decisions, to understand this document, and to have signed it voluntarily.

- I am not related to the declarer by blood, marriage, or state registered domestic partnership.
- I am not a home care provider for the declarer.
- I do not provide care at an adult family home or long-term care facility where the declarer lives.

Witness 1

Signature

Print Name

Address

Witness 2

Signature

Print Name

Address