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SKAMANIA CO. WASH
BY Vickie Jensen

Oct 30 4 30 PM '98
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AUDITOR
GARY M. OLSON

Return Address:

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PO Box 163
Stevenson, WA 98648

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Indexing information required by the Washington State Auditor's/Recorder's Office. (RCW 36.18 and RCW 65.04) 1/97: (please print last name first)
Reference # (if applicable):
Grantor(s) (Principal): (1) (2) Addl'. on pg
Grantee(s)(Attorney in Fact) (1) (2) Addl'.on pg
Legal Description (abbreviated):
Addl'. legal is on page Assessor's Property Tax Parcel/Account #

1. **DESIGNATION OF ATTORNEY-IN-FACT AS HEALTH CARE AGENT**
I, Tola E. Hopkins PO Box 163 Stevenson, WA 98648 (Insert name and address), do hereby designate and appoint Vickie Lynn Jensen and Mary Ann Hopkins PO Box 453 Stevenson WA 98648 * (Insert name, address, and telephone of designated health care agent), as my attorney-in-fact (agent), to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, non-treatment, as provided in Chapter 7.70 RCW, service, or procedure to maintain, diagnose, or treat an individual's physical condition. * 509-427-4829 and/or 509-427-5471

2. **CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE**
By this document I intend to create a durable power of attorney for health care. This power of attorney shall not be affected by my disability or incompetence and shall continue in full force and effect until revoked or terminated as set forth in paragraph 9.

3. **GENERAL STATEMENT OF AUTHORITY GRANTED**
Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services and procedures. Provided, however, my agent may not consent, without court approval, to any procedure referred to in R.C.W. 11.92.040(3) that requires court approval before a guardian may consent to such.

4. **STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS**
In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires and is subject to the special provisions and limitations stated in any living will which I have executed.

5. **INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH**
Subject to any limitations in this document, my agent has the power and authority to do all of the following:
   a. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.
   b. Execute on my behalf any releases or other documents that may be required in order to obtain this information.

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d. Consent to the donation of any of my organs for medical purposes.

6. **SIGNING DOCUMENTS, WAIVERS AND RELEASES**
Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:
a. Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice".
b. Any necessary waiver or release from liability required by a hospital or physician.
c. Any documents pursuant to the power of substitution in the premises, which I hereby, grant to my agent subject to my choice of alternates below.

7. **DESIGNATION OF ALTERNATE AGENTS**
If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:
a. First Alternate Agent: n/a
_____ (Insert name, address and telephone number of first alternate agent)
b. Second Alternate Agent: n/a
_____ (Insert name, address and telephone number of second alternate agent)

8. **PRIOR DESIGNATIONS REVOKED**
I revoke any prior durable power of attorney for health care.

9. **TERMINATION**
This power of attorney may be terminated by written notice, court approval of revocation, recording a notice with the County Auditor/Recorder, and shall be automatically revoked upon my death but only upon actual notice or knowledge of such by my agent.

10. **APPLICABLE LAW**
The laws of the State of Washington of the United States of America shall govern this power of attorney.

Dated October 28, 1998 Iola E. Hopkins

STATE OF WASHINGTON,

ss. **INDIVIDUAL ACKNOWLEDGEMENT**

County of Klickitat

I certify that I know or have satisfactory evidence that Iola E. Hopkins is the person who appeared before me, and said person acknowledged that She signed this instrument and acknowledged it to be her free and voluntary act for the uses and purposes mentioned in the instrument.

Dated this 28th of October, 1998

Peggy B Lowry

Print Name Peggy B. Lowry

Notary Public in and for the State of Washington

My appointment expires: 2/23/99

PEGGY B. LOWRY NOTARY PUBLIC STATE OF WASHINGTON COMMISSION EXPIRES 2-23-99

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