Skamania County, WA
Total:$258.50
POA
Pgs=6
Request of: SCOTT MCKEON

2021-003078
09/09/2021 12:38 PM

00010368202100030780060067

WHEN RECORDED RETURN TO:

Scott McKeon
1087 Lewis River Rd
P.O Box 184
Woodland WA 98674

Please print or type information **Washington State Recorder's Cover Sheet** (RCW 65.04)

DOCUMENT TITLE(S) (or transaction contained therein) (all areas applicable to your document must be filled in)

Healthcare Durable POA

REFERENCE NUMBER(S) of Documents assigned or released:

[ ] Additional numbers on page _____ of document.

GRANTOR(S):

1. Scott McKeon 2. _____

3. _____ 4. _____

[ ] Additional names on page _____ of document.

GRANTEE(S):

1. Kevin McKeon 2. _____

3. _____ 4. _____

[ ] Additional names on page _____ of document.

LEGAL DESCRIPTION (Abbreviated: i.e. Lot, Block, Plat or Section, Township, Range, Quarter):

[ ] Complete legal on page _____ of document.

Assessor's Property Tax Parcel #

[ ] Additional parcel numbers 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.

"I am signing below and paying an additional $50.00 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 herby 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."

Scott McK
Signature of Requesting Party

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

HEALTH CARE

DURABLE POWER OF ATTORNEY

for

SCOTT LEONARD MCKEON

I, SCOTT LEONARD MCKEON, a resident of the state of Washington. hereby revoke any and all powers of attorney relating to health care matters executed by me previous to this date. I hereby grant a Durable Power of Attorney to KEVIN SCOTT MCKEON (referred to below as the "attorney-in-fact") to take effect immediately, with the intention that this designation of Durable Power of Attorney shall remain in effect and not be limited should I become incapacitated. If for any reason KEVIN SCOTT MCKEON is unable or unwilling to act as attorney-in-fact, I hereby designate AMANDA MCKEON as alternate attorney-in-fact. An attorney-in-fact shall be deemed to be unable to act if such inability to act is confirmed by an examining doctor's statement or other sufficient evidence.

1. **Effectiveness.** This power of attorney shall be effective immediately and shall not be affected by the incapacity of the principal.

2. **HIPAA Personal Representative.** I hereby give my attorney-in-fact the presently effective power to receive my protected health information from all of my health care providers and from all health care facilities (which have any pertinent records) and to authorize the disclosure and use of my protected health information and to give informed consent for health care decisions on my behalf as my Personal Representative under the Health Insurance Portability and Accountability Act of 1996, as provided in 45 CFR Part 164. Furthermore, I intend that this instrument be a valid disclosure authorization in accordance with RCW 70.02.030.

3. **Powers.** In addition to the powers set forth in paragraph 2 above, my attorney-in-fact shall act as a fiduciary for me and shall have full power and authority to take actions and to make decisions relating to the health and personal care to be provided to me, and the withholding or withdrawal of life-sustaining treatment from me. Provided, the authority granted to my attorney-in-fact will be subject to the same limitations as those that apply to a guardian under RCW 11.92.043(5), as amended.

(a) **Health and Personal Care.** My attorney-in-fact shall have the authority to make health and personal care decisions for me, which authority shall include, but shall not be limited to:

(l) arranging for my hospitalization, convalescent care, hospice, home care, and for the provision of other health care services;

(2) employing and discharging medical personnel as my attorney-in-fact shall deem necessary for my physical, mental and emotional well-being, and paying such personnel (or causing to be paid to them) reasonable compensation;

(3) consenting, refusing consent, or withdrawing or withholding consent for diagnostic or medical treatment for a physical or mental condition, including, but not limited to. the administration of pain-relieving drugs and surgical or medical procedures;

(4) obtaining access to medical and health care records and other personal information, including, but not limited to, medical and hospital records; executing any releases or other documents that may be required in order to obtain such information: and disclosing such information as my attorney-in-fact deems appropriate;

(5) signing, executing and delivering any contract, waiver, release of liability or other document (including refusal for treatment in "Leaving Hospital Against Medical Advice") that may be necessary, desirable, convenient or proper in order to exercise any power created under this durable power of attorney, and incurring reasonable expenses in the exercise of such powers;

(6) having first priority in visitation should I be a patient in any hospital, health care facility, hospice or institution and should I be unable to express a preference because of illness or disability;

(7) making arrangement for my funeral, burial, cremation (or other disposition of my remains), including the purchase of a burial plot and marker and such other related arrangements, if I have not already done so;

(8) making anatomical gifts of part or all of my body for medical purposes and authorizing an autopsy, if deemed advisable or necessary in the sole discretion of my attorney-in-fact, and directing the disposition of my remains, to the extent permitted by law; and

(9) taking possession of all personal property belonging to me that may be recovered from or about my person at the time of my illness, disability or death.

(b) **Life-Sustaining Treatment.** The power and authority granted to my attorney-in-fact shall specifically include, but shall not be limited to, taking action and making decisions regarding the withholding or withdrawal of life-sustaining treatment as may be appropriate given my then medical condition, and to give the necessary consent thereto to the fullest extent permitted by law.

(1) Without limiting the generality of the foregoing, such medical condition shall include, but shall not be limited to: (i) an incurable and irreversible condition (if I am

unconscious) caused by injury, disease, or illness certified in writing to be a terminal condition by my attending physician, where the application of life-sustaining treatment would serve only to artificially prolong the moment of my death and where my physician determines that my death will occur within a reasonable period of time in accordance with accepted medical standards; and (ii) a condition which has been certified in writing by two physicians to be a permanent unconscious condition and where the application of life-sustaining treatment would serve only to artificially prolong the moment of my death.

(2) Life-sustaining treatment shall include, but shall not be limited to, a respirator, antibiotics, cardiopulmonary resuscitation and dialysis. In addition, life-sustaining treatment shall also include artificially provided hydration or nutrition, or both, if I authorize my attorney-in-fact to withhold or withdraw artificially provided hydration or nutrition, or both, in subparagraph (c) below.

(c) **Hydration and Nutrition.** If I am diagnosed to be in a terminal condition or in a permanent unconscious condition:

_____ initial	_____ check	I **DO** want to have artificially provided nutrition.
SM initial	X check	I **DO NOT** want to have artificially provided nutrition.
_____ initial	_____ check	I **DO** want to have artificially provided hydration.
SM initial	X check	I **DO NOT** want to have artificially provided hydration.

If I direct that I do not wish to have artificially provided hydration or nutrition, or both, my attorney-in-fact shall have the authority to direct my health care provider to withhold or withdraw artificially provided hydration or nutrition. I understand that if I authorize my attorney-in-fact to direct the withholding or withdrawal of artificially provided hydration or nutrition, or both, and my attorney-in-fact exercises this power, dehydration, malnutrition and death will result.

4. **Duration.** The authority of my attorney-in-fact to act on my behalf shall become effective as provided in paragraph I above and shall remain in effect until revoked or until my death (subject to paragraph 6(b) below).

5. **Revocation.** I may revoke this Power of Attorney by giving written notice to my attorney-in-fact.

6. **Termination**

(a) **By Appointment of Guardian.** If a guardian is appointed for me, such guardian shall. with court approval, have the power to revoke, suspend or terminate this Power of Attorney.

(b) **By Death.** My death shall be deemed to revoke this Power of Attorney upon actual knowledge or actual notice being received by the attorney-in-fact. Provided, my attorney-in-fact shall have continued authority for ten (10) days upon the actual knowledge or the actual notice of my death to exercise the powers set forth in subparagraphs 3(a)(7) through 3(a)(9) above.

7. **Reliance.** My attorney-in-fact and all persons dealing with the attorney-in-fact shall be entitled to rely upon this Power of Attorney so long as it is effective and has not been revoked. Any action taken in reliance on this document, unless otherwise invalid or unenforceable, shall be binding on my heirs, devisees, legatees, or personal representative. Further, any physician, health care provider acting under the direction of a physician, or health facility and its personnel who participate in good faith in the withholding or withdrawal of life sustaining treatment shall be immune from legal liability, including civil, criminal or professional conduct sanctions, unless otherwise negligent.

8. **Nomination of Guardian of Person.** I nominate my attorney-in-fact for consideration by the Court as my guardian or limited guardian in the event that any protective proceedings regarding my person are commenced.

9. **Reimbursement.** My attorney-in-fact shall be entitled to reimbursement for all reasonable costs and expenses incurred on my behalf in exercising the power granted herein.

10. **Severability.** If any provision of this Power of Attorney is invalid or unenforceable under applicable law, this Power of Attorney shall be ineffective to the extent of such invalidity only, without affecting the remaining parts hereof.

11. **Indemnity.** My estate shall hold harmless and indemnify my attorney-in-fact from all liability for acts done in good faith and not in fraud.

12. **Applicable Law.** The laws of the state of Washington, as amended, shall govern this Power of Attorney.

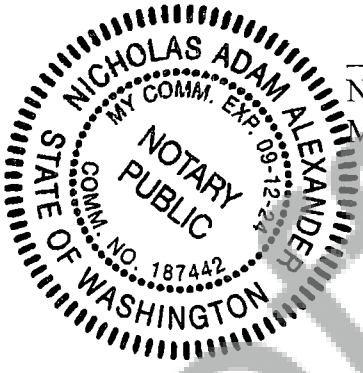
THIS power of attorney is signed this 25 day of AUGUST, 2021, to become effective as provided in paragraph 1.

SCOTT LEONARD MCKEON

STATE OF WASHINGTON)
:ss.
COUNTY OF CLARK)

I certify SCOTT LEONARD MCKEON appeared personally before me and that I know or have satisfactory evidence that SCOTT LEONARD MCKEON signed this Durable Healthcare Power of Attorney instrument and acknowledged it to be signed as a free and voluntary act for the use and purpose mentioned in the instrument.

GIVEN under my hand and official seal this 25th day of Aug, 2021.



Notary Public for Washington
My commission expires: 9/12/24