Durable Power of Attorney for Health Care Decisions of WILLIAM D. HOOD

I, WILLIAM D. HOOD, presently residing and domiciled in King County, the State of Washington, hereby revoke any other Powers of Attorney for Health Care Decisions I may have previously executed, and in their place execute this Durable Power of Attorney for Health Care Decisions as follows:

1. **Designation.** I hereby designate M. EILEEN HOOD as my Health Care Agent pursuant to RCW 11.125 and as it is amended in the future. In the event that M. EILEEN HOOD is unable or unwilling to serve, I hereby designate MARALISE HOOD QUAN or STEVEN L. HOOD as my Co-Health Care Agents pursuant to RCW 11.125 and as it is amended in the future. Where the term "or" is used in this paragraph, it shall mean that any one individual so named may at any time act as Health Care Agent, independently of the other and they shall not be required to act jointly. Either Health Care Agent's signature or act under the authority of this document shall be accepted by all third persons as fully authorized by the Principal. In the event that none of my named Health Care Agents are able or willing to serve, my last serving Health Care Agent shall have the authority under RCW 11.125.110(2) to appoint a Successor Health Care Agent.

2. **Powers.** My Health Care Agent shall have 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 Health Care Agent shall make a substituted judgment for me, and make the decision for me that he or she believes I would have made if I had the capacity to understand all the circumstances. In making any decision, my Health Care Agent shall attempt to

discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Health Care Agent cannot determine the choice I would want made, then my Health Care Agent shall make a choice for me that is based upon what my Health Care Agent believes to be in my best interests. My Health Care Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

The powers granted to my Health Care Agent shall include but not be limited to:

2.1 providing informed consent to medical and surgical care and non-treatment for me, including the administration of drugs;

2.2 signing a Physician's Orders for Life-Sustaining Treatment (POLST) form for me;

2.3 signing any necessary waivers or releases from liability required by a hospital or physician to implement my wishes regarding medical treatment or refusal of treatment;

2.4 arranging for my hospitalization, convalescent care, hospice, home health care, or home care, including my admission to a medical, nursing, residential, or similar facility, or removing me from any health care facility to another facility, a private home, or other place; executing any consent or admission forms required by such facility, and entering into any agreement for my care at such facility or elsewhere, during my lifetime or for such less periods of time as my Health Care Agent may designate;

2.5 arranging for the employment and discharge of health care personnel including physicians, psychiatrists, dentists, nurses, and therapists as my Health Care Agent shall deem necessary for my physical, mental and emotional well-being;

2.6 summoning paramedics or other emergency medical personnel and to seek emergency treatment for me, as my Health Care Agent deems appropriate;

2.7 interpreting any instructions in my Health Care Directive or in other discussions, according to my Health Care Agent's understanding of my wishes and values;

2.8 making anatomical gifts of part or all of my body for medical purposes, and authorizing an autopsy, to the extent permitted by law;

2.9 under circumstances in which my Health Care Agent determines that certain medical procedures, tests, or treatments are no longer of benefit to me, or where the benefits are outweighed by the burdens imposed, to withdraw, revoke, modify or change consent to such procedures, tests, and treatments as well as hospitalization, convalescent care, hospice or home care I or my Health Care Agent may have previously allowed or consented to or which may have been provided due to emergency conditions. Such power shall include the authority to withhold or withdraw life-sustaining treatment for me, or to take any action necessary to give effect to the provisions of my Health Care Directive;

2.10 my Health Care Agent is not authorized to restrict the social aspects of my life, including but not limited to visits from friends and family, except to the extent my Agent in good faith deems such restrictions necessary to protect my physical, mental and emotional well-being.

3. Effectiveness and Duration.

3.1 By this document, I intend to create a Durable Power of Attorney effective at any time when, in the opinion of my Health Care Agent or my treating health care provider, I am unable to understand a decision and give informed consent or I am unable to communicate my decision regarding particular health care decisions.

Even when I cannot make my own health care decisions, I want my physician and my Health Care Agent to talk to me honestly about my condition and treatment, if they think I might understand.

3.2 Receive and Exchange Information – Effective Immediately. My Health Care Agent shall be authorized to receive information in my health care records and exchange information with any of my health care providers, including information regarding my health history, any diagnosis, treatment, or prognosis I have or have had, even if such includes information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. I understand that once the above information is

disclosed, it may be redisclosed by my Health Care Agent and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of this information identified is voluntary. This authorization shall not be conditioned upon my incapacity, but shall be effective immediately so that my Health Care Agent can effectively participate in and be informed about my health care. As to my Health Care Agent designated herein, I hereby waive all privileges attached to the physician/patient relationship, and to any communication, verbal or written, arising out of such a relationship.

3.3 This Power of Attorney shall remain in effect regardless of my disability, incapacity, incompetence, or inability to give informed consent unless revoked by me.

4. **Statement of Wish.** In exercising the powers authorized by this Power of Attorney, my Health Care Agent should be guided by, but not limited by, any instructions set forth in my Advance Health Care Directive, if I have executed one, and as otherwise made known by me to my Health Care Agent.

5. **Reliance.** Any person acting without negligence and in good faith in reasonable reliance on this Power of Attorney shall not incur any liability thereby, so long as they have no actual knowledge nor actual notice of any revocation, suspension or termination of this Power of Attorney by death or otherwise. Any action so taken, unless otherwise invalid or unenforceable, shall be binding on me, my relatives, or on the inheritors of my estate.

6. **Compensation and Expenses.** The Health Care Agent shall be reimbursed for all costs and expenses reasonably incurred. In addition, the Health Care Agent shall be entitled to receive at least annually, without court approval, reasonable compensation for services performed on my behalf. The Health Care Agent may waive this right to compensation from time to time.

7. **Reliance on Photocopy Hereof.** Third parties shall be entitled to rely upon a copy of this instrument which has been certified by any Notary Public to be a true copy hereof to the same effect as though such copy were the original.

8. **Intent to Avoid Need for Guardianship.** It is my intent that the powers given to the Health Care Agent designated herein be interpreted to be so broad as to avoid the need for the appointment of a guardian for my person. If the appointment of a guardian or limited guardian of my person is sought, however, I

nominate the persons designated above as Health Care Agent and alternate Health Care Agent as guardian or limited guardian of the person, in the same order of priority, subject to the confirmation of the Court.

9. **Applicable Law.** The laws of the State of Washington shall govern this Power of Attorney.

DATED this 4th day of November, 2021.

WILLIAM D. HOOD
Domiciled and Residing in Seattle,
King County, Washington

STATE OF WASHINGTON)
) ss.
COUNTY OF KING)

This is to certify that on this date, WILLIAM D. HOOD personally appeared before me, the undersigned Notary Public, to me known to be the person described in and who executed the foregoing Durable Power of Attorney for Health Care Decisions and acknowledged to me that he signed the same as his voluntary act and deed, for the uses and purposes therein mentioned.

SUBSCRIBED AND SWORN to before me this 4 day of November, 2021.

ELIZABETH F JENNINGS
NOTARY PUBLIC
158660
COMMISSION EXPIRES
3-11-24
STATE OF WASHINGTON

ELIZABETH F. JENNINGS
NOTARY PUBLIC in and for the State of Washington, residing at Lynnwood, WA
My commission expires March 11, 2024

Initials