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# How to Complete Your Washington Mental Health Advance Directive

Mental Health Advance Directive (RCW 71.32)

**INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.**

**About this form.** A Washington mental health advance directive lets you state your mental health treatment preferences in advance and name an agent to decide for you during a crisis.

1. **Write your preferences (Pages 1–2)**
   Choose whether it can be revoked during incapacity, name an agent, and describe your preferences.
2. **Sign one of two ways (Pages 2–3)**
   Sign before **two qualified witnesses** or a **notary**. Your agent signs the acceptance. We can provide witnesses for an additional fee.

## After It's Signed

- Give copies to your agent, doctors, and mental health providers.

## Need a Notary and Witnesses? We Come to You.

Homes • Hospitals • Care Facilities • Offices • Available Anytime
Qualified witnesses available for an additional fee.

**Washington-Commissioned Notaries**

SCAN TO BOOK

**Questions about this document? Talk to an attorney.** Gavrilov & Brooks Law Firm has attorneys licensed in multiple states. Phone and video consultations are available, wherever you are. **(916) 504-0529** · **www.gavrilovlaw.com**

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YOUR FORM BEGINS ON THE NEXT PAGE

# MENTAL HEALTH ADVANCE DIRECTIVE

(Washington, RCW 71.32)

I,

Full legal name | Date of birth

Address

being a capable adult, make this mental health advance directive under chapter 71.32 RCW, to be followed if I am found to be incapacitated.

**1. When effective. This directive becomes effective when I am found to be incapacitated as provided in chapter 71.32 RCW. (Initial one:)**

☐ I may revoke this directive at any time when I am not incapacitated.

☐ I may **not** revoke this directive while I am incapacitated (irrevocable while incapacitated).

**2. Agent (optional). I appoint the following agent to make mental health treatment decisions for me:**

Name | Address | Telephone

Alternate agent | Address | Telephone

**3. Medications I consent to, refuse, and why:**

**4. Admission to inpatient treatment (consent, refusal, and preferred facilities):**



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## 5. Other treatment and crisis plan (electroconvulsive therapy, who to notify, care of children or pets):

X _____
Signature

Date

**Sign in ONE of two ways:** before a **notary** (recommended) **or** before **two qualified witnesses**.

**OPTION 1: WITNESSES.** We declare that the person signing this directive is personally known to us or has provided proof of identity, signed or acknowledged it in our presence, and does not appear to be acting under duress or undue influence. Neither of us is the agent, the person's treating provider or an employee of that provider, or related to the person by blood, adoption, or marriage.

X _____
Witness

Printed name

X _____
Witness

Printed name



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## OPTION 2: NOTARY ACKNOWLEDGMENT

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

This record was acknowledged before me on

(date) by (name of the person making this directive)

**X**
Notary Public

(Notary seal)

Notary's printed name

Title (Notary Public, State of Washington) My commission expires

**ACCEPTANCE BY AGENT.** I accept this appointment and agree to act in good faith according to the person's wishes.

**X**
Agent signature Date



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