MENTAL HEALTH CARE POWER OF ATTORNEY

Statutory Form

I, _____ , being an adult of sound mind, voluntarily make this declaration for mental treatment. I want this declaration to be followed if I am incapable, as defined in Section 36-3281, Arizona Revised Statutes. I designate _____ _____ (include the person's name, address and telephone number) as my agent for all matters relating to my mental health care including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related mental health care. If my agent is unable or unwilling to serve or continue to serve, I appoint _____ . (include the person's name, address, and telephone number) as my agent. I want my agent to make decisions for my mental health care treatment that are consistent with my wishes as expressed in this document or, if not specifically expressed, as are otherwise known to my agent.

If my wishes are unknown to my agent, I want my agent to make decisions regarding my mental health care that are consistent with what my agent in good faith believes to be in my best interests. My agent is also authorized to receive information regarding proposed mental health treatment and to receive, review and consent to disclosure of any medical records relating to that treatment.

This declaration allows me to state my wishes regarding mental health care treatment including medications, admission to and retention in a health care facility for mental health treatmental and outpatient services.

(Initial one of the following)

_____ **This mental health care power of attorney is irrevocable if I am incapable of revoking it.**

_____ **This mental health care power of attorney is revocable at all times.**

The following are my wishes regarding my mental health care treatment if I become incapable, as defined in Section 36-3281, Arizona Revised Statutes:

I consent to the following mental health treatment:

_____

_____

_____

_____

Note: If in the above paragraph you have expressly consented to giving your agent the power to admit you to an inpatient or partial psychiatric hospitalization program, please initial here:

Note: If in the above paragraph you have expressly consented to giving your agent the power to consent to medical treatment against your wishes only pursuant to the development of a specific treatment plan that is reviewed and approved by a physician, please initial here:

I do not consent to the following mental health treatments:

_____

_____

_____

Additional information about my mental health care treatment needs: (consider including mental or physical health history, dietary requirements, religious concerns, people to notify and any other other matters that you feel are important).

This mental health care power of attorney is made pursuant to Title 36, Chapter 32, Article 6, Arizona Revised Statutes, and continues in effect for all who may rely on it except to those I have given notice of its revocation pursuant to Section 36-3285.

(Signature of Principal) _____

Affirmation of Witnesses:

I affirm that the person signing this mental health care power of attorney:

1. Is personally known to me.
2. Signed or acknowledged by his or her signature on this declaration in my presence.
3. Appears to be of sound mind and not under duress, fraud or undue influence.
4. Is not related to me by blood, marriage or adoption.
5. Is not a person for whom I directly care as a professional.
6. Has not appointed me as an agent to make medical decisions on his or her behalf.

Witnessed By:

_____ (Signature and Date)

_____ (Signature and Date)

Acceptance of Appointment as Agent:

I accept this appointment and agree to serve as Agent to make mental health treatment decisions for the Principal. I understand that I must act consistently with the wishes of the person I represent, as expressed in this Mental Health Care Power of Attorney, or if not expressed, as otherwise known by me. If I do not know the Principal's wishes, I have a duty to act in what I in good faith believe to be that person's best interests. I understand that this document gives me the authority to make decisions about mental health treatment only while the peson has been determined to be incapable as that term is defined in Section 36-3281, Arizona Revised Statutes.

_____ _____

(Signature of Agent) Address

_____ ( )

(Printed Name of Agent) Phone Number