

# **MENTAL HEALTH CARE POWER OF ATTORNEY**

(Arizona Revised Statutes 36-3281 *et seq.*)

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 \_\_\_\_\_ 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 care related to my mental health condition. If my agent is unable or unwilling to serve or continue to serve, I appoint \_\_\_\_\_, 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 treatment and outpatient services.

(initial one of the following)

\_\_\_\_\_ This mental health care power of attorney is irrevocable if I am unable to give informed consent.

\_\_\_\_\_ 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 treatments:

By initialing here, I consent to giving my agent the power to admit me to an inpatient or partial psychiatric hospitalization program, please initial here: \_\_\_\_\_ (initial if you consent)

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 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)

Address of agent: \_\_\_\_\_

Telephone number of agent: \_\_\_\_\_

Address of backup agent: \_\_\_\_\_

Telephone number of backup agent: \_\_\_\_\_

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 provide 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: (optional)

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 that person has been determined to be incapable as that term is defined in section 36-3281, Arizona Revised Statutes.

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(signature of agent)

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(printed name of agent)