STATE OF ARIZONA
DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY
Instructions and Form

GENERAL INSTRUCTIONS: Use this Durable Mental Health Care Power of Attorney form if you want to appoint a person to make future mental health care decisions for you if you become incapable of making those decisions for yourself. The decision about whether you are incapable can only be made by an Arizona licensed psychiatrist or psychologist who will evaluate whether you can give informed consent. Be sure you understand the importance of this document. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctor, clergyperson, and a lawyer before you sign this form.

If you decide this is the form you want to use, complete the form. **Do not sign this form until** your witness or a Notary Public is present to witness the signing. There are more instructions about signing this form on page 3.

1. Information about me: (I am called the "Principal")

My Name: _____ My Age: _____
My Address: _____ My Date of Birth: _____
_____ My Telephone: _____

2. Selection of my health care representative and alternate: (Also called an "agent" or "surrogate")

I choose the following person to act as my representative to make mental health care decisions for me:

Name: _____ Home Telephone: _____
Street Address: _____ Work Telephone: _____
City, State, Zip: _____ Cell Telephone: _____

I choose the following person to act as an alternate representative to make mental health care decisions for me if my first representative is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Telephone: _____
Street Address: _____ Work Telephone: _____
City, State, Zip: _____ Cell Telephone: _____

3. Mental health treatments that I AUTHORIZE if I am unable to make decisions for myself:

Here are the mental health treatments I authorize my mental health care representative to make on my behalf if I become incapable of making my own mental health care decisions due to mental or physical illness, injury, disability, or incapacity. If my wishes are not clear from this Durable Mental Health Care Power of Attorney or are not otherwise known to my representative, my representative will, in good faith, act in accordance with my best interests. This appointment is effective unless and until it is revoked by me or by an order of a court. My representative is authorized to do the following **which I have initialed or marked**:

_____ **A. About my records:** To receive information regarding mental health treatment that is proposed for me and to receive, review, and consent to disclosure of any of my medical records related to that treatment.
_____ **B. About medications:** To consent to the administration of any medications recommended by my treating physician.
_____ **C. About a structured treatment setting:** To admit me to a structured treatment setting with 24hour-a-day supervision and an intensive treatment program licensed by the Department of Health Services, which is called a "level one" behavioral health facility.
_____ **D. Other:** _____
_____
_____

DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY (Cont'd)

4. Durable Mental health treatments that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself: (Explain or write in "None")

_____
_____
_____

5. Revocability of this Durable Mental Health Care Power of Attorney: This Durable Mental Health Care Power of Attorney is made under Arizona law and continues in effect for all who rely upon it except those who have received oral or written notice of its revocation. Further, I want to be able to revoke this Durable Mental Health Care Power of Attorney as follows: (Initial or mark A or B.)

_____ **A.** This Durable Mental Health Care Power of Attorney is IRREVOCABLE if I am unable to give informed consent to mental health treatment.

_____ **B.** This Durable Mental Health Care Power of Attorney is REVOCABLE at all times if I do any of the following:

1.) Make a written revocation of the Durable Mental Health Care Power of Attorney or a written statement to disqualify my representative or agent.
2.) Orally notify my representative or agent or a mental health care provider that I am revoking.
3.) Make a new Durable Mental Health Care Power of Attorney.
4.) Any other act that demonstrates my specific intent to revoke a Durable Mental Health Care Power of Attorney or to disqualify my agent.

6. 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):

_____
_____
_____

HIPPA WAIVER OF CONFIDENTIALITY FOR MY AGENT/REPRESENTATIVE

_____ **(Initial)** I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1320d and 45 CFR 160-164.

SIGNATURE OR VERIFICATION

A. I am signing this Durable Mental Health Care Power of Attorney as follows:

My Signature: _____ Date: _____

B. I am physically unable to sign this document, so a witness is verifying my desires as follows:

Witness Verification: I believe that this Durable Mental Health Care Power of Attorney accurately expresses the wishes communicated to me by the Principal of this document. He/she intends to adopt this Durable Mental Health Care Power of Attorney at this time. He/she is physically unable to sign or mark this document at this time. I verify that he/she directly indicated to me that the Durable Mental Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Mental Health Care Power of Attorney at this time.

Witness Name (printed): _____

Signature: _____ Date: _____

DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY (Last Page)

SIGNATURE OF WITNESS OR NOTARY PUBLIC

NOTE: At least one adult witness OR a Notary Public must witness the signing of this document and then sign it. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this document is signed.

A. Witness: I affirm that I personally know the person signing this Durable Mental Health Care Power of Attorney and that I witnessed the person sign or acknowledge the person's signature on this document in my presence. I further affirm that he/she appears to be of sound mind and not under duress, fraud, or undue influence. He/she is not related to me by blood, marriage, or adoption and is not a person for whom I directly provide care in a professional capacity. I have not been appointed as the representative to make medical decisions on his/her behalf.

Witness Name (printed): _____
Signature: _____ Date and time: _____
Address: _____

B. Notary Public: (NOTE: If a witness signs your form, you DO NOT need a notary to sign)

STATE OF ARIZONA) ss
COUNTY OF _____)

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Durable Mental Health Care Power of Attorney has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to the person signing above, by blood, marriage or adoption, or a person designated to make medical decisions on his/her behalf. I am not directly involved in providing care as a professional to the person signing. I am not entitled to any part of his/her estate under a will now existing or by operation of law. In the event the person acknowledging this Durable Mental Health Care Power of Attorney is physically unable to sign or mark this document, I verify that he/she directly indicated to me that the Durable Mental Health Care Power of Attorney expresses his/her wishes and that he/she intends to adopt the Durable Mental Health Care Power of Attorney at this time.

WITNESS MY HAND AND SEAL this ____ day of _____, 20___.
Notary Public: _____ My commission expires: _____

OPTIONAL:
REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

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 Durable 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 incapacitated which means under Arizona law that a licensed psychiatrist or psychologist has the opinion that the Principal is unable to give informed consent.

Representative Name (printed): _____
Signature: _____ Date: _____