

DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY

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 mental health care representative and alternate (Also called “agent or surrogate”)

I choose the following persons to act as my co-representatives to make mental health care decisions for me when I am incapable of making them for myself.

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

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If for any reason one of my co-representatives shall fail to qualify or act hereunder as my lawful attorney-in-fact, then the other shall serve as my successor attorney-in-fact, to act with all of the powers as herein provided.

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 Mental Health Care Power of Attorney or are not otherwise known to my representatives, my representatives 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 representatives are 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 24-hour-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: _____

_____.

4. **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 Mental Health Care Power of Attorney.** This 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 Mental Health Care Power of Attorney as follows: (Initial or mark A, or B.)

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

B. This 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 mental health care power of attorney or a written statement to disqualify my representatives or agents.
2. Orally notify my representatives or agents or a mental health care provider that I am revoking.
3. Make a new Mental Health Care Power of Attorney.
4. Any other act that demonstrates my specific intent to revoke a mental health care power of attorney or to disqualify my agents.

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).

_____.

SIGNATURE OR VERIFICATION

A. I am signing this 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:

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 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 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: _____

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THIS MENTAL HEALTH CARE POWER OF ATTORNEY AND LIVING WILL IS A
BINDING
LEGAL DOCUMENT. IF NOT UNDERSTOOD, PLEASE CONSULT AN ATTORNEY.

Furnished Compliments of:

Mesch, Clark & Rothschild, P.C.
ATTORNEYS AT LAW
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