ARIZONA MENTAL HEALTH POWER OF ATTORNEY FORM

IMPORTANT INFORMATION

This power of attorney authorizes another person (your agent) to make decisions for you (the principal). Your agent will be able to make decisions and act on your behalf, whether or not you are able to act for yourself.

This power of attorney does not authorize the agent to make health care decisions for you. Such powers are governed by applicable laws for Advance Directives.

You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

If your agent is unable or unwilling to act for you, your power of attorney will end unless you have named a successor agent. You may also name a second successor agent.

This power of attorney becomes effective immediately unless you state otherwise in the Special Instructions.

If you have questions about the power of attorney or the authority you are granting to your agent, you should seek legal advice before signing this form.

The following forms are available from the National Resource Center on Psychiatric Advance Directives.

OFFICE OF THE ARIZONA ATTORNEY GENERAL Mark Brnovich

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 a specialist in neurology or 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 Phone: _____
Address: _____
Work Phone:_____ _____
_____ Cell Phone: _____

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 Phone:_____
Address: _____
Work Phone:_____ _____
_____ Cell Phone: _____

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:

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

☐ **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 an inpatient psychiatric facility. ☐ **D. Other:** .

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 mental health care power of attorney or any portion of it may not be revoked and any designated agent may not be disqualified by me during times that I am found to be unable to give informed consent. However, at all other times I retain the right to revoke all or any portion of this mental health care power of attorney or to disqualify any agent designated by me in this document.

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): _____

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HIPAA 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: _____

DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY (Last Page)

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

Proxy 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.

Proxy Name (printed): _____

Date: _____

Signature:

SIGNATURE OF WITNESS

NOTE: At least one adult witness, not to include the proxy above, 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. If choosing the signature of a Notary Public instead of a witness, write "N/A" on each line below and go to the next page.

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 to make medical decisions on his/her behalf.

Witness Name (printed): _____

Signature: _____ Date: _____

Address: _____

NOTORIAL JURAT:

NOTE: The following jurat pertains to the foregoing two pages of the State of Arizona Durable Mental Healthcare Power of Attorney dated_____, 20_____.

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

STATE OF ARIZONA) ss
COUNTY OF _____)

_____

NAME OF PRINCIPAL/PROXY

Subscribed and sworn (or affirmed) before me 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 specialist in neurology or a licensed psychiatrist or psychologist has the opinion that the Principal is unable to give informed consent.

Representative Name (printed): _____

Signature: _____Date:_____