ARKANSAS 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.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

_____

OF

[*Name of Declarant*]

Pursuant to the Arkansas Durable Power of Attorney for Health Care Act (Ark. Code Ann.§20-13-104) (the "Act"), I hereby designate and appoint _____ as my agent, or attorney in fact, to make decisions regarding my health care during periods when my health care provider has determined that I lack capacity to decide for myself. Specifically, and not to limit any other rights prescribed under the Act, my attorney-in-fact shall have the power to have access to my medical records for treatment or payment decisions; to disclose medical records to others for purposes of treatment, payment, or health care operations; to employ and discharge physicians; to consent to or refuse to consent to medical procedures, including the withholding or withdrawal of life-sustaining treatment, and nutrition and hydration, according to my wishes expressed in my Living Will, or, if my wishes are unclear under the then existing circumstances of my medical condition, then upon consideration of my best interests as determined by my physician in consultation with my agent; to admit me to hospitals, including psychiatric hospitals, nursing homes, or hospice care; and to sign all appropriate forms, consents and releases in connection with any of said matters.

If _____ resigns, or is not able or available to make health care decisions for me, or if an agent named by me is divorced from me or is my spouse and legally separated from me, I appoint _____ as successor, with all of the rights and powers and authority herein stated. The term "health care" shall have the meaning set forth in Ark. Code Ann. § 20-13-104(c). This Durable Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity.

SIGNED this _____ day of _____, 20____.

_____

Signature

We, the undersigned do hereby certify that the Declarant, _____ subscribed this Durable Power of Attorney for Health Care in our presence, and we, at his or her request, in his or her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that his or her signature was voluntary.

_____ _____

Witness Witness

_____ _____

Address Address

City, State and Zip Code	City, State and Zip Code