MARYLAND 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.

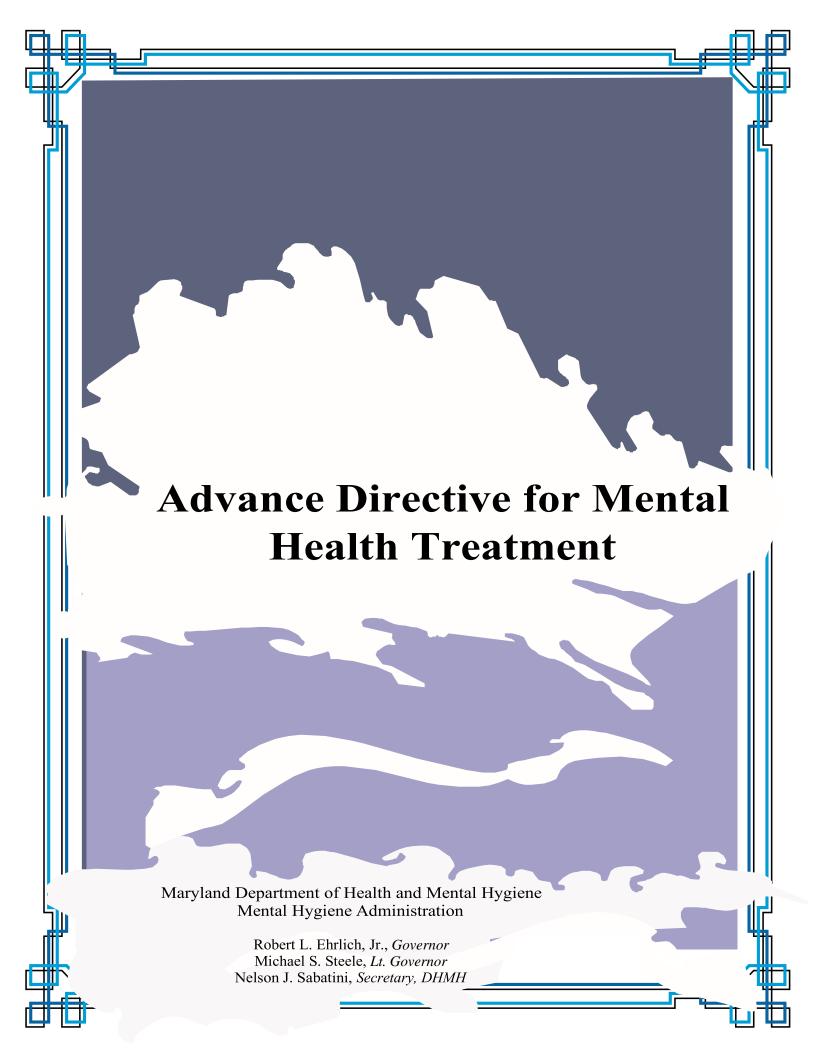
You should select someone you trust to serve as your agent. Unless you specify otherwise, generally the agent's authority will continue until you die or revoke the power of attorney or the agent resigns or is unable to act for you.

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.

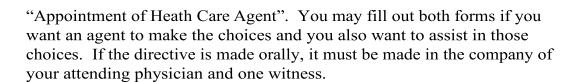


NOTICE: This is an important legal document. Before signing this document, you should know these important facts.

Introduction

Maryland law gives the right to anyone 16 years of age and over to be involved in decisions about their mental health treatment. However, a parent or guardian of a person under the age of 18 years may authorize treatment, even over the objection of the minor. The law also notes that at times, some persons are unable to make treatment decisions. Maryland law states that you have the right to make decisions in advance, including mental health treatment decisions, through a process called advance directive. An advance directive can be used to state your treatment choice or can be used to name a health care agent, that is someone that will make health care decisions for you.

- A. If you are a person with a mental illness, this document provides you the chanceto take part in a major way in your mental health care decisions when you are not able to. This document allows you to express your consent or refusal to medications for your mental illness and other health care decisions, including use of seclusion and restraints. Please know that Maryland law allows a health care provider to override your refusal for medication for a mental disorder in limited situations if you are involuntarily committed to a psychiatric hospital.
- B. This document may be completed by any individual 18 years of age and has notbeen determined to be not capable of making an informed decision. An advance directive may be oral or written. If written, it must be signed and dated. Two witnesses must also sign the document. The health care agent may not be a witness. And, at least one witness may not be a person who is knowingly entitled to benefit by your death, for example inherit money, insurance benefits. The witnesses must sign the document stating that the person making the directive is personally known to them and appears to be of sound mind.
- C. If you wish to guide your health care providers on what treatment you wish tohave if you should become unable to give consent, and you DO NOT WANT A HEALTH AGENT, fill out the form titled "Advance Directive for Mental Health Treatment". If you want an agent to make the choice for you, fill out the form



- D. You can also make an advance directive naming a person as your health care agent, to make mental health decisions when you are not able to do so. The agent must make choices in line with any desires you have expressed in this document, or if your wishes are not expressed and are not known by the agent, the agent must act in good faith in what he/she believes to be in the best interest for you. It is your job to inform the agent that the agent has been named in your advance directive, and to make sure he/she agrees to be your agent. It is important that your health care agent be informed about your mental illness and the decisions you have made in this form. It is highly recommended that you discuss the contents of this form with your family and close friends and your mental health providers.
- E. Maryland law does not allow a person to sign another adult into a psychiatric hospital. Therefore, a health care agent may not sign you into a psychiatric hospital.
- F. Maryland law allows giving a medication for the treatment of a mental disorder over the person's expressed wishes, or placing a person in seclusion or restraints against the person's expressed wishes, under certain conditions.

Advance Directive for Mental Health Treatment _____, being an adult, and emotionally and mentally able to make this directive, willfully and freely complete this health care advance directive to be followed if it is determined by two physicians that I am not able as a result of a psychiatric or physical illness to assist in my health care treatment. (The second physician may not be involved in my treatment). It is my intent that care will be carried out despite my inability to make choices on my own behalf. In the event that a guardian or other decision-maker is chosen by a court to make health care choices for me, I intend this document to take priority over all other means of discovering my intent while able. The usual symptoms of my identified mental disorder may include: __ I direct my health care providers to follow my choices as set forth below: Medications for treatment of my mental illness: If I become unable to make informed choices for treatment of my mental illness, my wishes regarding medications are as follows: I may be allergic to the following medications: Medication Reaction

own brand-name, trade name or generic equal. Medication Reason for not agreeing ———————————————————————————————————	╬	
Initial all that apply: I agree to the performance of all tests and other means to identify or assess my mental health. I agree to the performance of all tests and other means to check how well the medications are working and their effect on my body, i.e. blood tests. I specifically do not agree with dispensing the following medications, or their own brand-name, trade name or generic equal. Medication		
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medications are working and their effect on my body, i.e. blood tests. I specifically do not agree with dispensing the following medications, or their own brand-name, trade name or generic equal. Medication Reason for not agreeing I agree with dispensing all medications prescribed by my treating psychiatrist unless listed above. Admission to and continuation of Mental Health Services from a facility other than an inpatient hospital. Check one I do not have a preference about receiving mental health services from a facility or other provider than a psychiatric hospital, i.e., clinic, PRP, mobile treatment.		
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facility or other provider than a psychiatric hospital, i.e., clinic, PRP, mobile treatment.		Check one
I agree to receive services from a facility, which is not a hospital.		facility or other provider than a psychiatric hospital, i.e., clinic, PRP, mobile
		I agree to receive services from a facility, which is not a hospital.
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		I do not agree to receive mental health services from a provider or facility other than a hospital.	
		Conditions/ Limits:	
		Other Choices	
		If I am unable to make informed decisions about my mental health choices, my wishe regarding other information or options are listed below:	S
		_	
		Release of Records	
		I authorize the release of (check one): any and all mental health records the following montal health records of the following moviders:	
		the following mental health record/records of the following providers:	
		to:	
[₩	(name of person records may be released to)	4
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Cross through this page if you do not want to appoint a health care agent to make decisions for you.

Name	
Address	
Work Number	Home Number
If this agent is unable, unv select the following persor	villing, or elsewhere engaged to act as my agent, then I is to act in this role:
Name:	
Address	
	Home Number
If my wishes are known to my ago to make health conditional determined by might result from	e not expressed above, and my wishes are not otherwise ent, or if my wishes are unknown or unclear, my agent is are choices for me with my best interest in mind, to be my agent after reviewing the benefits, burdens, risks that in a given treatment or course of treatment, or from the withdrawal of a treatment or course of treatment.
	is subject to the following conditions and limits:

