MONTANA 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 AND MEDICAL TREATMENT

I , _____ of the City of _____, State of Montana, do hereby make, constitute, nominate and appoint _____presently residing in_____, County, State of Montana, as my true and lawful attorney-in-fact to act for me andin my place and stead for the purpose of making any and all decisions regarding my health and, medical care and treatment at any time that I may be, by reason of physical, mental disability, incompetency or incapacity, incapable of making decisions on my behalf.

1. I grant said attorney-in-fact complete and full authority to do and perform all andevery act and thing whatsoever requisite, proper and necessary to be done in the exercise of the rights herein granted, as fully for all intents and purposes as I mightor could do if personally present and able with full power of substitution or revocation, hereby ratifying and confirming all that said attorney-in-fact shall lawfully do or cause to be done by virtue of this power of attorney and the rights and powers granted herein.

2. If, at any time, I am unable to make or communicate decisions concerning my medical care and treatment, by virtue of physical, mental or emotional disability,incompetency, incapacity, illness or otherwise, my said attorneyin-fact shall have the authority to make all health care decisions and all medical care and treatment decisions for me and on my behalf, including consenting or refusing to consent toany care, treatment, service or procedure to maintain, diagnose or treat my mentalor physical condition.

3. In the absence of my ability to give directions regarding my health care, it is my intention that my said attorney-in-fact shall exercise this specific grant of authority and that such exercise shall be honored by my family,physicians, nurses, and any other health care provider(s) or facility in which or by which I may be treated, as afinal expression of my legal rights.

4. This power of attorney is durable and will continue to be effective if I become disabled, incapacitated, or incompetent.

5. This durable power of attorney is effective in any state that I may seek or receive medical-treatment and health care.
6. I specifically direct all health care providers, including physicians, nurses, therapists and medical and hospital staff to follow the directions of my attorney-in-fact and such decisions are superior to and shall take precedence over any decisions made by any member of my family.

7. The rights, powers, and authority of said attorney-in-fact herein granted shall commence and be in full force and effect immediately.

8. If any agent named by me dies, becomes incompetent, resigns or refuses to accept the office of agent, I name the following persons (each to act alone and successively, in the order named) as successor(s) to the agent:

A. _____

B. _____

9. Special instructions: On the following lines I give special instructions limiting or extending the powers granted to my agent.

_____

_____

_____

10. I hereby designate _____ to determine whether I am unable to make or communicate decisions concerning my medical care and treatment by virtue of my physical, mental, or emotional disability, incompetency, incapacity, illness or otherwise. This determination will be provided in writing and attached to this Durable Power of Attorney For Health Care and Medical Treatment.

Dated this _____ day of _____, _____.

Signature of Principal:

_____

Social Security Number: _____ - _____ - _____.

State of Montana
County of _____

Subscribed, sworn to and acknowledged before me this _____day

of _____, _____.

(Notarial Seal)

_____
Notary Public For the State of Montana
Residing at _____
My commission expires: _____