OREGON 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.

DECLARATION FOR MENTAL HEALTH TREATMENT

127.736 Form of declaration. A declaration for mental health treatment shall be in substantially the following form:

I, _____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment. I want this declaration to be followed if a court or two physicians determine that I am unable to make decisions for myself because my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means treatment of mental illness with psychoactive medication, admission to and retention in a health care facility for a period up to 17 days, convulsive treatment and outpatient services that are specified in this declaration

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CHOICE OF DECISION MAKER

If I become incapable of giving or withholding informed consent for mental health treatment, I want these decisions to be made by: (INITIAL ONLY ONE)

__ My appointed representative consistent with my desires, or, if my desires are unknown by my representative, in what my representative believes to be my best interests.

__ By the mental health treatment provider who requires my consent in order to treat me, but only as specifically authorized in this declaration.

APPOINTED REPRESENTATIVE

If I have chosen to appoint a representative to make mental health treatment decisions for me when I am incapable, I am naming that person here. I may also name an alternate representative to serve. Each person I appoint must accept my appointment in order to serve. I understand that I am not required to appoint a representative in order to complete this declaration.

I hereby appoint: NAME _____

ADDRESS _____

TELEPHONE # _____

to act as my representative to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment. (OPTIONAL)

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my representative, I authorize the following person to act as my representative:

I hereby appoint: NAME _____

ADDRESS _____

TELEPHONE # _____

My representative is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my representative. If my desires are not expressed and are not otherwise known by my representative, my representative is to act in what he or she believes to be my best interests. My representative is also authorized to receive information regarding proposed mental health treatment and to receive, review and consent to disclosure of medical records relating to that treatment.

DIRECTIONS FOR MENTAL HEALTH TREATMENT

This declaration permits me to state my wishes regarding mental health treatments including psychoactive medications, admission to and retention in a health care facility for mental health treatment for a period not to exceed 17 days, convulsive treatment and outpatient services.

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes are:

I CONSENT TO THE FOLLOWING MENTAL HEALTH TREATMENTS: (May include types and dosage of medications, short-term inpatient treatment, a preferred provider or facility, transport to a provider or facility, convulsive treatment or alternative outpatient treatments.)

_____

_____

_____

_____

_____

_____

_____

I DO NOT CONSENT TO THE FOLLOWING MENTAL HEALTH TREATMENT: (Consider including your reasons, such as past adverse reaction, allergies or misdiagnosis. Be aware that a person may be treated without consent if the person is held pursuant to civil commitment law.)

_____

_____

_____

_____

ADDITIONAL INFORMATION ABOUT MY MENTAL HEALTH TREATMENT NEEDS: (Consider including mental or physical health history, dietary requirements, religious concerns, people to notify and other matters of importance.)

YOU MUST SIGN HERE FOR THIS DECLARATION TO BE EFFECTIVE:

(Signature/Date)

AFFIRMATION OF WITNESSES

I affirm that the person signing this declaration:

(a) Is personally known to me;
(b) Signed or acknowledged his or her signature on this declaration in my presence;
(c) Appears to be of sound mind and not under duress, fraud or undue influence;
(d) Is not related to me by blood, marriage or adoption;
(e) Is not a patient or resident in a facility that I or my relative owns or operates;
(f) Is not my patient and does not receive mental health services from me or my relative; and
(g) Has not appointed me as a representative in this document.

Witnessed by:

(Signature of Witness/Date) (Printed Name of Witness)

(Signature of Witness/Date) (Printed Name of Witness) ACCEPTANCE OF APPOINTMENT AS REPRESENTATIVE

I accept this appointment and agree to serve as representative to make mental health treatment decisions. I understand that I must act consistently with the desires of the person I represent, as expressed in this declaration or, if not expressed, as otherwise known by me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document gives me authority to make decisions about mental health treatment only while that person has been determined to be incapable of making those decisions by a court or two physicians. I understand that the person who appointed me may revoke this declaration in whole or in part by communicating the revocation to the attending physician or other provider when the person is not incapable.

_____ _____

(Signature of Representative/Date) (Printed Name of Witness)

_____ _____

(Signature of Alternate Representative/Date) (Printed Name of Witness)