OFFICE OF THE ARIZONA ATTORNEY GENERAL
MARK BRNOVICH

Mental Health Care Power of Attorney

GENERAL INSTRUCTIONS: Use this form if you want to appoint a person, also referred to as your "agent", 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. It is a good idea to talk to your doctor and loved ones if you have questions about the type of mental health care you do or do not want.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it. **PLEASE NOTE:** At least one adult witness OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one, a witness is legally accepted.

Witnesses 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 agent
(e) involved in providing your health care at the time this form is signed

My Information (I am the "Principal"):

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

Selection of my mental health care power of attorney and alternate:

I choose the following person to act as my agent 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 to make mental health care decisions for me if my first agent is unavailable, unwilling, or unable to make decisions for me:

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

_____ Cell Phone: _____

Mental health treatments that I AUTHORIZE if I am unable to make decisions for myself:

Here are the mental health treatments I authorize my agent to make for me if I become incapable of making my own mental health care decisions due to mental or physical illness, injury, disability, or incapacity. This appointment is effective unless and until it is revoked by me or by an order of a court. My agent is authorized to do the following which I have initialed or marked:

_____**:** To receive medical records and information regarding my mental health treatment and to receive, review, and consent to disclosure of any of my medical records related to that treatment.

_____**:** To consent to the administration of any medications recommended by my treating physician.

_____**:** To admit me to an inpatient or partial psychiatric hospitalization program.

_____**:** Other: _____

_____

_____

Mental health care treatments that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself: (Explain or write in "None")

_____

_____

Revocability of this 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.

HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT

_____ **(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 of 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.

MY SIGNATURE VERIFICATION FOR THE MENTAL HEALTH CARE POWER OF ATTORNEY

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document your witness/notary may sign and initial for you. If applicable, have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Health Care Power of Attorney expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS (See Page 1 for who CANNOT be a witness)

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form. I affirm that I meet the requirements to be a witness as indicated on page one of the mental health care power of attorney form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY (See Page 1 for who CANNOT be a Notary)

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

NOTORIAL JURAT: Pertains to all three pages of this State of Arizona Mental Health Care Power of Attorney dated _____, 20_____.

STATE OF ARIZONA) ss

COUNTY OF _____)

_____

Principal's Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____

My Commission Expires: _____