

# MENTAL HEALTH CARE POWER OF ATTORNEY

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**GENERAL INSTRUCTIONS:** Use this Mental Healthcare Power of Attorney form if you want to appoint a person to make future mental healthcare 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 licensed psychiatrist or psychologist who will evaluate whether you can give informed consent. Be sure you understand the importance of this document. Talk to your family members, friends and others you trust about your choices. Also, it is a good idea to talk to professionals such as your doctor, clergy person, and a lawyer before you sign this form. If you decide this is the form you want to use, complete the form. Do not sign the form until your witness or a Notary Public is present to witness the signing.

**Information about me (I am called the "Principal"):**

My Name: \_\_\_\_\_  
My Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

My Age: \_\_\_\_\_  
My Date of Birth: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_  
Work Telephone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

I designate the following person to serve as my Agent for all matters relating to my mental health care including, without limitation, full power to give or refuse consent to all medical care related to my mental health condition (Selection of my mental healthcare representative and alternate (Also called an "Agent" or Surrogate")):

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_  
Work Telephone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

I choose the following person to act as an Alternate Representative to make mental healthcare decisions for me if my first representative is unavailable, unwilling or unable to serve or continue to serve:

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_  
Work Telephone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

I, \_\_\_\_\_, being an adult of sound mind, voluntarily make this declaration for mental treatment. I want this declaration to be followed if I am incapable. If my wishes are not clear from this Mental Health Care Power of Attorney or are not otherwise known to my representative, my representative will, in good faith, act in accordance with my best interests. This appointment is effective unless and until it is revoked by me or by an order of a court. My representative is authorized to do the following:

**Initial next to each section if you consent:**

- \_\_\_\_\_ **A. About my records:** To receive information regarding mental health treatment that is proposed for me and to receive, review and consent to disclosure of any of my medical records related to that treatment.
- \_\_\_\_\_ **B. About medications:** To consent to the administration of any medications recommended by my treating physician.
- \_\_\_\_\_ **C. About a structured treatment setting:** To admit me to an inpatient or partial psychiatric hospitalization program, including a level one behavioral health facility.
- \_\_\_\_\_ **D. Other:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The following are my wishes regarding my mental health care treatment if I become incapable, as defined in section 36-3281, Arizona Revised Statutes (incapable means "that in the opinion of a physician who is licensed pursuant to title 32, chapter 13 or 17 and who is a specialist in psychiatry or a psychologist who is licensed pursuant to title 32, chapter 19.1, a person's inability to give informed consent as defined in section 36-501"):

I do not consent to the following mental health treatments if I am unable to make decisions for myself (Explain or write "None"):

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Additional information about my mental health care treatment needs (consider including mental or physical health history, dietary requirements, religious concerns, people to notify and any other matters that you feel are important):

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**Revocability of this Mental Healthcare Power of Attorney:** This Mental Healthcare Power of Attorney is made under Arizona law and continues in effect for all who rely upon it except those who have received oral or written notice of its revocation. Further, I want to be able to revoke this Mental Healthcare Power of Attorney as follows:

A. This Mental Health Care Power of Attorney is IRREVOCABLE if I am unable to give informed consent to mental health treatment.

\_\_\_\_\_  
Initials

B. This Mental Health Care Power of Attorney is REVOCABLE at all times if I do any of the following:

\_\_\_\_\_  
Initials

1. Make a written revocation of the Mental Healthcare Power of Attorney or a written statement to disqualify my Agent.
2. Orally notify my Agent or a mental healthcare provider that I am revoking the Mental Healthcare Power of Attorney.
3. Make a new Mental Healthcare Power of Attorney.
4. Any other act that demonstrates my specific intent to revoke a Mental Healthcare Power of Attorney or to disqualify my Agent.

### Principal's Signature or Verification

I am signing this Mental Healthcare Power of Attorney as follows:

Signature or Mark of Principal: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Signature of Witness or Notary Public**

Note: At least one adult witness OR a Notary Public must witness the signing of this document and then sign it. The witness 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 representative; or (e) Involved in providing your healthcare at the time this document is signed.

**1. Witness Section** (Witness shall select one of the two boxes below, and sign and date the document as required).

- o **Witness Certification:** I certify that I have witnessed the signing of this document by the Principal. The person who signed this Mental Healthcare Power of Attorney appeared to be of sound mind and under no pressure to make specific choices or to sign the document. I understand the requirements of being a witness and I confirm the following:
  - I have not been designated to make medical decisions for the person who signed this Mental Healthcare Power of Attorney;
  - I am not directly involved with providing healthcare to this person;
  - I am not related to this person by blood, marriage, or adoption;
  - I am not entitled to any part of this person's estate upon his death under a Will or by operation of law.

**OR**

- o **Witness Verification:** The Principal is physically unable to sign or mark this document, so as witness I am verifying the Principal's desires as follows:

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I believe that this Mental Healthcare Power of Attorney accurately expresses the wishes communicated to me by the Principal of this document. He/she is physically unable to sign or mark this document at this time. I verify that he/she directly indicated to me that the Mental Healthcare Power of Attorney expresses his/her wishes and that he/she intends to adopt the Mental Healthcare Power of Attorney document at this time.

Witness Name (Printed): \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Witness Address: \_\_\_\_\_

Date: \_\_\_\_\_

**2. Notary Public:** Note: A Notary Public is only required if no witness signed above.

STATE OF ARIZONA                    )  
   ) ss.  
 County of                                )

The undersigned, being a Notary Public certified in Arizona, declares that the person making this Mental Healthcare Power of Attorney has dated and signed or marked it in my presence and appears to me to be of sound mind and free from duress. I further declare I am not related to the person signing above by blood, marriage, or adoption, nor am I a person designated to make medical decisions on his/her behalf. I am not directly involved in providing healthcare to the person signing. I am not entitled to any part of his/her estate under a Will now existing or by operation of law. In the event the person acknowledging this Mental Healthcare Power of Attorney is physically unable to sign or mark this document, I verify that he/she directly indicated to me that this Mental Healthcare Power of Attorney expresses his/her wishes and that he/she intends to adopt the Mental Healthcare Power of Attorney at this time.

WITNESS MY HAND AND SEAL this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Notary Public \_\_\_\_\_ My Commission Expires \_\_\_\_\_