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How to Complete Your Arizona Mental Health Care Power of Attorney

Mental Health Care Power of Attorney • A.R.S. § 36-3286

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. This form lets you name an agent to make mental health treatment decisions for you if you are found incapable, and lets you write which treatments you do and do not want. It follows Arizona's sample form.

1. **Name your agent and a backup**
   Include addresses and phone numbers.
2. **Write your treatment wishes**
   List treatments you consent to and those you do not. Initial if your agent may admit you to inpatient care.
3. **Add helpful information**
   Health history, medications that worked or did not, people to notify.
4. **Sign before a notary or one qualified witness**
   Use one or the other. We recommend a notary.

Signing requirements: Arizona requires a notary **or** one adult witness; the notary or witness cannot be your agent or anyone involved in your care (A.R.S. § 36-3282).

After It's Signed

- Give copies to your agent, your psychiatrist and treatment team.

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Have questions about your Mental Health Care Power of Attorney? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**.

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MENTAL HEALTH CARE POWER OF ATTORNEY

State of Arizona • A.R.S. §§ 36-3281 to 36-3287 • Based on the sample form in § 36-3286

Principal full name

I, the principal named above, being an adult of sound mind, voluntarily make this declaration for mental treatment. I want this declaration to be followed if I am incapable, as defined in A.R.S. § 36-3281. I designate the agent named below 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. If my agent is unable or unwilling to serve or continue to serve, I appoint the backup agent named below as my agent. I want my agent to make decisions for my mental health care treatment that are consistent with my wishes as expressed in this document or, if not specifically expressed, as are otherwise known to my agent.

Agent name

Telephone number of agent

Address of agent

Backup agent name

Telephone number of backup agent

Address of backup agent

If my wishes are unknown to my agent, I want my agent to make decisions regarding my mental health care that are consistent with what my agent in good faith believes to be in my best interests. My agent is also authorized to receive information regarding proposed mental health treatment and to receive, review and consent to disclosure of any medical records relating to that treatment.

This declaration allows me to state my wishes regarding mental health care treatment including medications, admission to and retention in a health care facility for mental health treatment and outpatient services.

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.

MY WISHES IF I BECOME INCAPABLE

I consent to the following mental health treatments

☐ By initialing here, I consent to giving my agent the power to admit me to an inpatient or partial psychiatric hospitalization program.

I do not consent to the following mental health treatments

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Additional information (mental or physical health history, dietary requirements, religious concerns, people to notify, other matters)

This mental health care power of attorney is made pursuant to title 36, chapter 32, article 6, Arizona Revised Statutes, and continues in effect for all who may rely on it except to those I have given notice of its revocation pursuant to A.R.S. § 36-3285.

Do not date or sign until your notary or witness is present.

X _____
Principal signature (or mark)

Date

VERIFICATION BY NOTARY OR WITNESS

Use **one** of the two options below: a notary public (Option A) **or** one qualified adult witness (Option B). Arizona law (A.R.S. § 36-3221) requires one or the other. The undersigned affirm(s) that the notary or witness was present when the principal dated and signed or marked this mental health care power of attorney, and that the principal appeared to be of sound mind and free from duress at the time of execution. The notary or witness further affirms that he or she is not: (1) under eighteen years of age; (2) designated to make medical decisions on the principal's behalf; or (3) directly involved with the provision of health care to the principal at the time this mental health care power of attorney is executed. If only one witness signs, that witness also affirms that he or she is not related to the principal by blood, marriage or adoption and is not entitled to any part of the principal's estate by will or by operation of law.

OPTION A — NOTARY ACKNOWLEDGMENT

STATE OF ARIZONA

COUNTY OF

On this _____ day of _____, 20____, before me personally appeared _____, the principal, who signed this mental health care power of attorney in my presence. I affirm the statements in the verification paragraph above.

X _____
Signature of Notary Public

Notary Public (printed name)

My commission expires

Commission number

(Notary seal)

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Option B — Statement of witness

I affirm under penalty of perjury the statements in the verification paragraph above.

X _____ Witness signature

Date

Witness printed name

Witness address

IF THE PRINCIPAL IS PHYSICALLY UNABLE TO SIGN OR MARK

The notary or witness verifies that the principal directly indicated that this mental health care power of attorney expresses the principal's wishes and that the principal intends to adopt it at this time.

X _____ Signature of notary or witness

Date

ACCEPTANCE OF APPOINTMENT AS AGENT (optional)

I accept this appointment and agree to serve as agent to make mental health treatment decisions for the principal. I understand that I must act consistently with the wishes of the person I represent, as expressed in this mental health care power of attorney, or if not expressed, as otherwise known by me. If I do not know the principal's wishes, I have a duty to act in what I in good faith believe to be that person's best interests. I understand that this document gives me the authority to make decisions about mental health treatment only while that person has been determined to be incapable as that term is defined in A.R.S. § 36-3281.

X _____ Signature of agent

Date

Printed name of agent

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