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How to Complete Your Ohio Declaration for Mental Health Treatment

Declaration for Mental Health Treatment (R.C. Chapter 2135)

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

About this form. An Ohio declaration for mental health treatment lets you state your treatment preferences in advance and name a proxy to make mental health decisions if a crisis leaves you unable to decide.

1. **Name a proxy and write preferences (Pages 1–2)**
   Describe medications, facilities, and treatments you want or do not want.
2. **Sign one of two ways (Pages 2–3)**
   Sign before **two qualified adult witnesses** or a **notary**. Witnesses cannot be related to you or be your proxy or provider. We can provide witnesses for an additional fee.

After It's Signed

- Give copies to your proxy, doctors, and mental health providers so it becomes part of your records.

Need a Notary and Witnesses? We Come to You.

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Witnesses available for an additional fee
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Have questions about this document? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**. Attorneys licensed in California, Nevada, and other states.

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DECLARATION FOR MENTAL HEALTH TREATMENT

(Ohio Revised Code Chapter 2135)

I,

Full legal name of declarant | Date of birth

Address

being an adult of sound mind, make this declaration for mental health treatment, to be followed if I lack the capacity to make informed decisions about my mental health treatment.

1. Proxy. I designate the following person as my proxy to make mental health treatment decisions for me, consistent with this declaration:

Name | Address | Telephone

Alternate proxy (optional) | Address | Telephone

2. Medications. My preferences about psychotropic medications (medications I consent to, do not consent to, and why):

3. Facilities and providers. My preferences about hospitals, treatment facilities, and providers:

4. Other treatment. My preferences about electroconvulsive therapy, other treatments, and anything my proxy may not consent to:

Declarant's initials: _____

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5. Other instructions (people to notify, care of children or pets, crisis plan):

6. Effect. This declaration revokes any earlier declaration for mental health treatment. I may revoke it at any time while I have capacity. A copy is as valid as the original.

Date

X _____
Signature of declarant

Printed name

Sign in ONE of two ways: before **two adult witnesses or** before a **notary**. Witnesses may not be related to you by blood, marriage, or adoption, and may not be your attending physician or the administrator of a nursing home where you receive care.

OPTION 1: WITNESSES.

I attest that the declarant signed or acknowledged this document in my presence, that the declarant appears to be of sound mind and not under or subject to duress, fraud, or undue influence. I further attest that I am not related to the declarant by blood, marriage, or adoption, I am not the declarant's proxy, attending physician, or mental health treatment provider, and I am not the administrator of a nursing home in which the declarant is receiving care.

X _____
Witness signature

Printed name

Date

Address

X _____
Witness signature

Printed name

Date

Address

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OPTION 2: NOTARY ACKNOWLEDGMENT

STATE OF OHIO)
COUNTY OF) **ss.**
)

On the date below, before me, a notary public, personally appeared the declarant named below, known to me or satisfactorily proven to be the person whose name is subscribed to this declaration, who acknowledged executing it and who appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

Name of declarant

Date

X

Notary Public

(Notary seal)

Notary's printed name

My commission expires

ACCEPTANCE BY PROXY (optional). I accept this designation and agree to act in good faith according to the declarant's wishes.

X

Proxy signature

Date

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