

**DURABLE POWER OF ATTORNEY
FOR MENTAL HEALTH CARE**

I, _____, am of sound mind and I
(Print or type your full name)
voluntarily make this designation.

APPOINTMENT OF PATIENT ADVOCATE

I designate _____, my _____,
(Insert name of patient advocate) (Spouse, child, friend ...)
living at _____,
(Address of patient advocate)
telephone number _____, as my patient advocate.

If my first choice cannot serve, I designate _____,
(Insert name of patient advocate)
my _____, living at _____
(Spouse, child, friend ...) (Address of patient advocate)
_____, telephone number _____, as my
patient advocate.

GENERAL POWERS

My patient advocate can only make decisions for me if a physician and a mental health professional determine I cannot give informed consent for mental health care.

My patient advocate or successor patient advocate must sign an acceptance before he or she can act. I have discussed this appointment with the individuals I have designated as patient advocate and successor patient advocate.

In making decisions, my patient advocate shall try to follow my wishes, whether I have talked about them or written them in this document or any other document.

My patient advocate has authority to consent to or refuse treatment as set forth below, and to pay for such services with my funds.

The individual I have chosen as my patient advocate shall have access to any of my medical and mental health records to which I have a right, immediately upon signing an Acceptance. In order to have such access, I appoint this individual as my “personal representative” as defined in the privacy provisions of the Health Insurance Portability and Accountability Act, and as my “authorized representative” as defined in the Michigan Medical Records Access Act.

SPECIFIC POWERS

I expressly authorize my patient advocate to make decisions concerning the following treatments, by writing my initials beside that treatment.

(It is my choice which treatments to initial)

_____ outpatient therapy

_____ my admission as a formal voluntary patient to a hospital to receive inpatient mental health services. I have the right to give three days notice of my intent to leave the hospital.

_____ my admission to a hospital to receive inpatient mental health services

_____ psychotropic medication

_____ electro-convulsive therapy (ECT)

_____ placement in a group residence

_____ seclusion and restraints

STATEMENT OF PREFERENCES

(optional)

1. The doctor and mental health professional I want to make the decision I am not able to give informed consent are -

2. If I need outpatient therapy, I prefer it to be provided by _____,
in the following setting: _____

3. If I need to be hospitalized for inpatient treatment, I prefer the following hospital:

_____.

4. If I need to be hospitalized, I prefer _____
to take me to the hospital.

5. If I need medication, I prefer to receive _____
at the following dose(s) _____. I do not want to receive the following medication
or medications: _____,
because _____

6. If I have given my patient advocate authority concerning ECT treatments, I want the
maximum number of treatments to be _____.

7. Additional wishes - _____

REVOCATION

(Initial one statement)

_____ I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

_____ I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days notice of my intent to leave a hospital if I am a formal voluntary patient.

LIABILITY

It is my intent no one involved in my care shall be liable for honoring my wishes as expressed in this designation or for following the directions of my patient advocate.

Photocopies of this document can be relied upon as though they were originals.

SIGNATURE

I sign this document voluntarily, and I understand its purpose.

Dated: _____

Signed: _____

(Your signature)

(Address)

ACCEPTANCE BY PATIENT ADVOCATE

(1) **This designation shall not become effective** unless the patient is unable to participate in decisions regarding the patient's mental health.

(2) **A patient advocate shall not exercise powers** concerning the patient's care, custody and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

(3) **A patient advocate shall not receive compensation** for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

(4) **A patient advocate shall act in accordance** with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests.

(5) **The known desires of the patient** expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.

(6) **A patient may revoke his or her designation** at any time or in any manner sufficient to communicate an intent to revoke.

(7) **A patient may waive his or her right to revoke** the patient advocate designation as to the power to make mental health treatment decisions, and if such waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

(8) **A patient advocate may revoke his or her acceptance** to the designation at any time and in any manner sufficient to communicate an intent to revoke.

(9) A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, Being Section 333.20201 of the Michigan Compiled Laws.

I, _____, understand the above
(Name of patient advocate)

conditions and I accept the designation as patient advocate or successor patient advocate for _____, who signed an
(Name of patient)

advance directive for mental health care on the following date:
_____.

Dated: _____

Signed: _____
(Signature of patient advocate or successor patient advocate)