

Mental Health Power of Attorney

(Print your name)

AUTHORIZING INPATIENT PSYCHIATRIC CARE

When I cannot make my own mental health care treatment decision, I want all such decision to be made for me by my health care agent _____ or, if I have appointed an alternate agent and my health care agent is unavailable or unwilling to serve, by my alternate health care agent _____ .

_____ I want admission to a “level one behavioral health care facility” or “inpatient psychiatric hospital, if a physician determines that this is in my best interests, andy agent agrees, at a time when I am unable to make my own mental health care treatment decisions, even if I oppose this.

Sign here in the presence of your witness

Date

STATEMENT OF WITNESS. I personally know the principle, and I believe him/her to be of sound mind and to have voluntarily (not under duress, fraud or undue influence) completed this health care power of attorney. I affirm that I am at least 18 years old, not related to him/her by blood, marriage or adoption, and not an agent named in this directive. I am not, to my knowledge, a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

Witness Signature

Date

Print witness name

Phone

Address

Note: This is a generic form. Each state has its own form, which you can find through your state’s Attorney’s General office or website. We are not attorneys and provide this only as a temporary form to use until you can get the correct form for your state.