MENTAL HEALTHCARE DECLARATION AND POWER OF ATTORNEY

State of Alabama

Part I. BACKGROUND

A. I, _____, having capacity to make mental health decisions, willfully and voluntarily make this declaration and Power of Attorney regarding my mental healthcare. I understand that mental healthcare includes any care, treatment, service or procedure to maintain, diagnose, treat, or provide for mental health, including any medication program and therapeutic treatment. Electroconvulsive therapy may be administered only if I have specifically consented to it in this document. I will be the subject of laboratory trials or research only if specifically provided for in this document. Mental healthcare does not include psychosurgery or termination of parental rights.

B. I authorize my designated mental healthcare agent to make certain decisions on my behalf regarding my mental healthcare. If i have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

C. I understand that my incapacity will be determined by examination by a psychiatrist and one of the following: another psychiatrist, psychologist, family physician, attending physician, or mental health treatment professional. Whenever possible, one of the decisionmakers will be one of my treating professionals.

Part II. MENTAL HEALTH DECLARATION

A. When Declaration Becomes Effective.

This declaration becomes effective when I am deemed incapable of making mental healthcare decisions by a physician, psychologist, or other mental healthcare professional.

B. Treatment Preferences.

1. Choice of treatment facility.

In the event that I require commitment to a psychiatric treatment facility, if at all reasonably possible, I would prefer to be admitted to the following facility:

_____

In the event that I require commitment to a psychiatric treatment facility, I do not wish to be committed to the following facility:

_____

I understand that, if this placement is not possible, I may be placed in a facility that is not my preference.

2. Use of medication for psychiatric treatment.

I consent to the use of medications that my treating physician recommends.

3. Use of electroconvulsive therapy (ECT).

I consent to the administration of electroconvulsive therapy as recommended by my treating physician.

4. Participation in experimental studies and drug trials.

I consent to participation in experimental studies if my treating physician believes that the potential benefits to me outweigh the possible risks to me.

I consent to participation in drug trials if my treating physician believes that the potential benefits to me outweigh the possible risks to me.

C. Revocation.

This declaration may be revoked in whole or in part at any time, either orally or in writing, as long as I have not been found to be incapable of making mental health decisions.

My revocation will be effective upon communication to my attending physician or other mental healthcare provider, either by me or a witness to my revocation, of the intent to revoke. If I choose to revoke a particular instruction contained in this Power of Attorney in the manner specified, I understand that the other instructions contained in this Power of Attorney will remain effective until:

(1) I revoke this declaration in its entirety;

(2) I make a new combined mental healthcare declaration and Power of Attorney; or

(3) two years after the date this document was executed.

D. Termination.

I understand that this declaration will automatically terminate two years from the date of execution unless I am deemed incapable of making mental healthcare decisions at the time this declaration would expire.

Date signed: _____

Part III. MENTAL HEALTHCARE POWER OF ATTORNEY

I, _____, having the capacity to make mental health decisions, authorize my designated healthcare agent to make certain decisions on my behalf regarding my mental healthcare. If I have not expressed a choice in this document or in the accompanying declaration, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

A. When Power of Attorney Becomes Effective.

This Power of Attorney becomes effective when I am deemed incapable of making mental healthcare decisions by a physician, psychologist, or other

mental healthcare professional.

B. Designation of Agent.

I hereby designate and appoint the following person as my agent to make mental healthcare decisions for me as authorized in this document. This authorization applies only to mental health decisions that are not addressed in the accompanying signed declaration:

Name: _____
Address: _____
Contact Info: _____

Agent's Acceptance:

I hereby accept designation as mental healthcare agent for _____ if he or she is ever found to be incapacitated and unable to make mental healthcare decisions. _____ has discussed their desires regarding mental healthcare decisions with me. If I choose to withdraw during the time the principal is competent, I must notify the principal of my decision. If I choose to withdraw when the principal is incapable of making the principal's health care decisions, I must notify the principal's physician.

_____
Signed: _____, Mental Healthcare Agent

_____
Date

C. Designation of Alternate Agent.

In the event that my first agent is unavailable or unable to serve as my mental healthcare agent, I hereby designate and appoint the following individual as my alternative mental healthcare agent to make mental healthcare decisions for me as authorized in this document:

Name: _____
Address: _____

Contact Info: _____

Alternate Agent's Acceptance:

I hereby accept designation as alternate mental healthcare agent for _____ if he or she is ever found to be incapacitated and unable to make mental healthcare decisions and their first choice of mental healthcare agent is unable to fill this role. _____ has discussed their desires regarding mental healthcare decisions with me. If I choose to withdraw during the time the principal is competent, I must notify the principal of my decision. If I choose to withdraw when the principal is incapable of making the principal's health care decisions, I must notify the principal's physician.

_____
Signed: _____, Alternate Mental Healthcare Agent

_____
Date

D. Authority Granted to Mental Healthcare Agent.

I hereby grant to my agent full power and authority to make mental healthcare decisions for me consistent with the instructions and limitations set forth in this Power of Attorney. If I have not expressed a choice in this Power of Attorney, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

E.

F. Termination.

I understand that this Power of Attorney will automatically terminate two years from the date of execution unless I am deemed incapable of making mental healthcare decisions at the time that the Power of Attorney would expire.

Part IV. COURT APPOINTED GUARDIAN

In the event a court decides to appoint a guardian, I desire the following person to be appointed:

Name: _____
Address: _____
Contact Info: _____

The appointment of a guardian of my person will give the guardian power to revoke, suspend, or terminate this declaration.

Part V. GOVERNING LAW

The laws of the state of Alabama shall govern this Mental Healthcare Declaration and Power of Attorney in all respects.

Part VI. NOTICE TO THIRD PARTIES

Any third party who relies on the reasonable representations of an agent regarding a matter relating to a power granted by a properly executed statutory Power of Attorney form shall not incur any liability to the principal, or the principal's heirs, assigns, or estate as a result of permitting the agent to exercise the authority granted by the Power of Attorney. A third party who fails to honor a properly executed statutory Power of Attorney may be liable to the principal, the agent, the principal's heirs, assigns, or estate for civil penalty, plus damages, costs, and fees associated with the failure to comply with the Mental Healthcare Declaration and Power of Attorney.

EXECUTION:

I, _____, the Principal, sign my name to this Power of Attorney on the date listed below and being first duly sworn, do declare to the undersigned authority that I sign and execute this instrument as my Power of Attorney and that I sign it willingly, or willingly direct another to sign for me, that I execute it as my free and voluntary act for the purposes expressed in the Power of Attorney and I declare that I am eighteen years of age or older, of sound mind and under no constraint or undue influence.

Name of Principal: _____

_____
_____, Principal

_____
Date

NOTARIZATION:

State of Alabama

County of:_____

On this _____ day of _____, 20__, before me, personally appeared _____, to me known to be the person described in and who executed the foregoing instrument, and acknowledged that they executed it as their free act and deed.

_____

Notary Signature, Printed Name, and Notary/Bar Roll Number

Statement of Witnesses:

I am of at least 18 years old. I declare under penalty of perjury that _____ signed or requested that another person sign this document on their behalf in my presence. _____ is personally known to me or provided me with evidence sufficient to convince me of their identity, and they signed this document voluntarily and appear to be of sound mind and under no duress, fraud, or undue influence.

I further declare that I am not _____'s spouse, parent, child, sibling, or otherwise related to _____ through blood, marriage, or adoption. I declare that I am not a person appointed as _____'s health care representative, not entitled to any portion of _____'s estate to the best of my knowledge, and not financially responsible for _____'s health care costs. I am not _____'s health care provider, an operator or employee of a care facility, or an operator or employee of a nursing home.

Witness 1:

_____
(Signature)

_____
(Date)

_____
(Print Name)

_____
(Full Address)

Witness 2:

_____
(Signature)

_____
(Date)

_____
(Print Name)

_____
(Full Address)