

**STATE OF ARIZONA
DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY**

I, **JOHN A. GREEN**, as Principal, of **CHANDLER, ARIZONA**, hereby appoint **NANCY A. GREEN** as my representative, for me and in my name to make mental health care decisions for me. If for any reason **NANCY A. GREEN** is unable or unwilling to act as such, I nominate **LINDA B. GREEN** as my representative. If for any reason **LINDA B. GREEN** is unable or unwilling to act as such, I nominate **PAUL B. GREEN** as my representative.

1. Mental health treatments that I AUTHORIZE if I am unable to make decisions for myself:

Here are the mental health treatments I authorize my mental health care representative to make on my behalf if I become incapable of making my own mental health care decisions due to mental or physical illness, injury, disability, or incapacity. If my wishes are not clear from this Durable Mental Health Care Power of Attorney or are not otherwise known to my representative, my representative will, in good faith, act in accordance with my best interests. This appointment is effective unless and until it is revoked by me or by an order of a court. My representative is authorized to do the following which I have initialed or marked:

_____ **A. About my records:** To receive information regarding mental health treatment that is proposed for me and to receive, review, and consent to disclosure of any of my medical records related to that treatment.

_____ **B. About medications:** To consent to the administration of any medications recommended by my treating physician.

_____ **C. About a structured treatment setting:** To admit me to a structured treatment setting with 24 hour-a-day supervision and an intensive treatment program licensed by the Department of Health Services, which is called a "level one" behavioral health facility.

_____ **D. Other:** _____

2. Durable mental health treatments that I expressly DO NOT AUTHORIZE if I am unable to make decisions for myself:

3. Revocability of this Durable Mental Health Care Power of Attorney: This Durable Mental Health Care Power of Attorney is made under Arizona law and continues in effect for all who rely upon it except those who have received oral or written notice of its revocation. Further, I want to be able to revoke this Durable Mental Health Care Power of Attorney as follows:

_____ **A.** This Durable Mental Health Care Power of Attorney is IRREVOCABLE if I am unable to give informed consent to mental health treatment.

_____ **B.** This Durable Mental Health Care Power of Attorney is REVOCABLE at all times if I do any of the following:

1. Make a written revocation of the Durable Mental Health Care Power of Attorney or a written statement to disqualify my representative or agent.
2. Orally notify my representative or agent or a mental health care provider that I am revoking.
3. Make a new Durable Mental Health Care Power of Attorney.
4. Any other act that demonstrates my specific intent to revoke a Durable Mental Health Care Power of Attorney or to disqualify my agent.

4. Additional information about my mental health care treatment needs (consider including mental or physical health history, dietary requirements, religious concerns, people to notify and any other matters that you feel are important):

HIPAA WAIVER OF CONFIDENTIALITY FOR MY AGENT/REPRESENTATIVE

_____ I intend for my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164.

SIGNATURE OR VERIFICATION

A. I am signing this Durable Mental Health Care Power of Attorney as follows:

