Advance Directive for Mental Health
pursuant to 43A O.S. § 11-106

I, _____, being of sound mind and eighteen (18) years of age or older, willfully and voluntarily make known my wishes about mental health treatment, by my instructions to others through my advanced directive for mental health treatment, or by my appointment of an attorney-in-fact, or both. I thus do hereby declare:

I. Declaration for Mental Health Treatment

If my attending physician or psychologist and another physician or psychologist determines that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment and that mental health treatment is necessary, I direct my attending physician or psychologist and other health care providers, pursuant to the Advance Directives for Mental Health Treatment Act, to provide the mental health treatment I have indicated below my signature.

I understand that "mental health treatment" means convulsive treatment, treatment with psychoactive medication, and admission to and retention in a health care facility for a period up to twenty-eight (28) days.

I direct the following concerning my mental health care:

_____

_____

I further state that this document and the information contained in it may be release to any requesting licensed mental health professional.

_____ _____
Declarant's Signature Date

_____ _____
Witness 1 Date

_____ _____
Witness 2 Date

II. Appointment of Attorney-In-Fact

If my attending physician or psychologist and another physician or psychologist determine that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment and that mental health treatment is necessary, I direct my attending physician or psychologist and other health care providers, pursuant to the Advance Directives for Mental Health Treatment Act, to follow the instructions of my attorney-in-fact.

I hereby appoint:

NAME _____

ADDRESS _____

TELEPHONE # _____ to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following person to act as my attorney-in-fact:

NAME _____

ADDRESS _____

TELEPHONE # _____

My attorney-in-fact is authorized to make decisions, which are consistent with the wishes I have expressed in my declaration. If my wishes are not expressed, my attorney-in-fact is to act in what he or she believes to be my best interest.

_____
(Signature of Declarant/Date)

III. Conflicting Provision

I understand that if I have completed both a declaration and have appointed an attorney-in-fact and if there is a conflict between my attorney-in-fact's decision and my declaration, my declaration shall take precedence unless I indicate otherwise.

_____
(Signature/Date)

IV. Other Provisions

a. In the absence of my ability to give directions regarding my mental health treatment, it is my intention that this advance directive for mental health treatment shall be honored by my family and physicians or psychologists as the expression of my legal right to consent or to refuse to consent to mental health treatment.

b. This advance directive for mental health treatment shall be in effect until it is revoked

c. I understand that I may revoke this advanced directive for mental health treatment at any time.

d. I understand and agree that if I have any prior advance directives for mental health treatment, and if I sign this advance directive for mental health treatment, my prior advance directives for mental health treatment are revoked.

e. I understand the full importance of this advance directive for mental health treatment and I am emotionally and mentally competent to make this advance directive for mental health treatment.

Signed this _____ day of _____, 20_____

_____
(Signature)

_____
City, Country and State of Residence

This advance directive was signed in my presence.

_____
(Signature of Witness)

_____
(Address)

_____
(Signature of Witness)

_____
(Address)

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