IDAHO: DECLARATION FOR MENTAL HEALTH TREATMENT

I, ____ being an adult of sound mind, willfully and voluntarily make this declaration of mental health treatment to be followed when I am unable to make decisions for myself or if it is determined by a court, two physicians that include a psychiatrist or one physician and a professional mental health clinician, 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. "Mental Health Treatment" means electroconvulsive treatment, treatment with psychotropic medication, or short-term admission to and retention in a health care facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder These symptoms may include:

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:
I consent to the following medications:
1. __________________________ 3. ____________________________
2. __________________________ 4. ____________________________
I do not consent to the administration of the following medications:
1. __________________________ 3. ____________________________
2. __________________________ 4. ____________________________
I also want it to be known that I have other health care concerns:

ADMISSION TO AND RETENTION IN A FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment my wishes regarding admission to and retention in a health care facility for mental health treatment are as follows:

(   ) I consent to being admitted to a health care facility for mental health treatment for up to_______ days for a minimum of _______days.

(   ) I do not consent to being admitted to a health care facility for mental health treatment.This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

ADDITIONAL REFERENCE OR INSTRUCTIONS:

Include additional directions such as (what you want/don't want from family, friends, Agent, professionals; what personal business you need others to do for you; what you anticipate being able to do for yourself, but if you can't, then what you would like done)

____
____
____
____
____
____
____
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____

I do not want the following people involved in my care or treatment:

____
____
____
____
____

FINANCIAL RESOURCES

The following financial resources are available for my care and treatment:

____
____
____
____
____

POWER-OF-ATTORNEY / CONSENT

[__] I have also executed a general power-of-attorney or a power-of-attorney under IdahoCode, Title 66 Chapter 6, that includes the power to make decisions regarding healthcare services for myself. I authorize the Agent appointed under a general powers-of-attorney under Idaho Code, Title 66, Chapter 6 to serve:
[__]Jointly with consent of each other as to my mental health treatment.
[__]Separately without each other's consent as to my mental health treatment.
[__]I have not executed a general power-of-attorney or a power-of-attorney under IdahoCode, Title 66, Chapter 6 that includes the power to make decisions regarding healthcare services for myself.

I affirm the above information to be my Declaration for Mental Health Treatment.

Signature (Name of Declarant/Date)

(Address)

(Telephone Number)

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for Mental Health Treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is a person appointed as an Agent by this document, the principal's attending physician or mental health service provider or a relative of the physician or provider; or the owner, operator, or relative of an owner or operator of a facility.

Witnessed By:

(Signature of witness / Date)

(Printed Name of Witness)

(Address)

(Telephone Number)

Witnessed By:

(Signature of witness / Date)

(Printed Name of Witness)

(Address)

(Telephone Number)

ATTACHMENT A (Optional)AUTHORIZATION TO RELEASE INFORMATION

I____,
(Name) (Address)
give my full consent to the following individual or agency:
Name:____

Address:____

City,State,Zip:____

to reciprocally exchange: __verbal __written __electronic information pertinent to my physical and/or mental condition and treatment as described below (example: progress notes,admission,physical,etc.):____
____
____
____
____
for the purpose of:
____
____with the following individual or agency:
Name:____
Address:____
City, State, Zip:____

I further understand this release of information is valid only until _________________,or until revoked orally or in writing by me or my Agent. It is also my understanding that this information will be used only for professional reasons and will not be further released, published, or disseminated without my permission. I understand that I may revoke this consent either orally, or in writing at any time.

CLIENT/REPRESENTATIVE SIGNATURE:

_____________________________"By my signature I hereby authorize the above identified individuals and agencies to release the information specified above, and release them from any responsibility and liability concerning the release of said information."

ATTACHMENT B
ACCEPTANCE OF APPOINTMENT AS AGENT

I accept this appointment and agree to serve as the Agent to make decisions about mental health treatment for the principal, ____.
(name of principal)

I understand that I have a duty to act in a manner consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment on behalf of the principal only while the principal is incapable as determined by a court, two physicians that include a psychiatrist, or one physician and a professional mental health clinician. I understand my decisions must be consistent with desires the principal has expressed in the declaration. Except to the extent these rights are limited by the declaration or any federal law, I have the same rights as the principal to receive information regarding the proposed mental health treatment and to receive, review and consent to disclosure of medical records relating to that treatment. This right of access does not waive any evidentiary privilege. If the principal's desires are not expressed in the declaration and not otherwise known by myself, I understand I have a duty to act in what I believe in good faith to be the best interest of the principal. I also understand that I am not subject to criminal prosecution, civil liability or professional disciplinary action for an action taken in good faith under this declaration for mental health treatment. I understand that I will not, as a result of acting in this capacity, be personally liable for the cost of treatment provided to the principal.
I understand that the principal may revoke this declaration in whole or in part at any time in any manner when the principal is not incapable and that I may withdraw by giving notice to the principal. If a principal is incapable, I may withdraw by giving notice to the attending physician or provider. I may also rescind the withdrawal by executing an acceptance after the date of the withdrawal and giving notice to the principal if the principal is capable or to the principal's health care provider if the principal is incapable.

Signature of Agent/Date:____

Printed Name: ____

Address: ____

Telephone Number : ____