## ARIZONA HEALTHCARE POWER OF ATTORNEY WITH OPTIONAL MENTAL HEALTH AUTHORITY

This form lets you choose a medical decision maker (healthcare power of attorney) if you cannot communicate or make those decisions yourself. A medical decision maker must be at least 18 years of age and should be someone who knows your wishes and values and who you trust to carry out your wishes. It may be a family member or friend.

By signing this form, you give your medical decision maker full power to make healthcare decisions for you, including to: 1) Choose your medical providers, caregivers, treatment options and where you receive care; 2) Agree to, refuse or withdraw life support or medical treatment. You may also choose to give your medical decision maker the power to make mental health decisions for you; and 3) Decide what happens to your body after you die, such as funeral arrangements and organ donation, if you have not made other arrangements.

**MEDICAL DECISION MAKER - I want this person to make my medical decisions if I am not able to make my own:**

_______________________ _______________________ _______________________ _______________________

First Name Last Name Relationship Phone

_______________________________________________ _______________________________________________

Address Email Address

**If the first person cannot do it, then I want this person to make my medical decisions:**

_______________________ _______________________ _______________________ _______________________

First Name Last Name Relationship Phone

_______________________________________________ _______________________________________________

Address Email Address

**MENTAL HEALTHCARE POWER OF ATTORNEY - This section must be initialed in front of a witness or a notary.**

____ Initial here, to allow your medical decision maker the power to make mental healthcare decisions for you.

____ Initial here, to allow your medical decision maker the power to admit you to an inpatient or partial psychiatric hospitalization program.

If there are mental health decisions you do not want them to make, write them here: ___________________________________

*This section may not be revoked if you are not able to make decisions for yourself, as determined by your physician.*

This is a legal document. By signing it, you acknowledge that you carefully reviewed it and that the information reflects your wishes regarding who can make medical decisions for you, what those decisions should be, and that those wishes should be honored. ***In order for this form to be valid, you must be at least 18 years old and have one witness or a notary watch you sign this form.***

___________________________________ _____________________ _______________________________

Sign Your Name Today's Date Date of Birth

_______________________ _____________________ _____________________________________________________

Print Your First Name Print Your Last Name Address:

**Witness**

I was present when this Medical Power of Attorney was signed and dated. The person seemed to be thinking clearly and was not forced to sign this Medical Power of Attorney. I also promise that I am: 1) at least 18 years of age; 2) not the person's medical decision maker; 3) not part of the person's healthcare team; 4) not related by blood, marriage, or adoption; and 5) not going to get any part of the person's estate (such as money or property) after he/she dies.

________________________________________________________ ______________________________________

Witness Signature Date

_______________________ _____________________ _____________________________________________________

Witness Print First Name Witness Print Last Name Address

**This document may be notarized instead of witnessed (optional).**

State of Arizona )

County of ____________________)

On this _____ day of _____________, 20____, before me personally appeared ______________________ whose identity was proven and he or she appeared to be of sound mind and free from duress, fraud or undue influence and he or she signed the above document.

_____________________________________

NOTARY PUBLIC

[Affix Seal Here]

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