

Advance Directive for Mental Health Treatment

This is a legal document under state law. It allows you to make decisions now about your future mental health treatment in the event that you are incapable of making those decisions.

1. My Information

Full Name

Date of Birth

Address

Phone Number

2. Designation of Mental Health Care Agent (Optional)

If I become incapable of making decisions about my mental health treatment, I designate:

Agent's Name

Relationship to Me

Agent's Phone Number

Agent's Address

3. Preferences for Mental Health Treatment

My preferences regarding mental health treatment (specific medications, therapies, hospitalizations, facilities, providers, etc.):

Any limitations or refusals of specific treatments:

4. Additional Instructions, Comments, or Information

Other instructions, comments, or information for my Agent or Treating Professionals:

5. Signature

Date

Printed Name

6. Witnesses

This Advance Directive must be signed in the presence of two adult witnesses.

Witness #1: Printed Name

Date

Witness #2: Printed Name

Date

Notice

This document is not valid unless you sign it and two qualified adult witnesses sign it in your presence as required by state law.