

PATIENT ADVOCATE DESIGNATION
FOR MENTAL HEALTH TREATMENT

NOTICE TO PATIENT

As the “Patient” you are using this Patient Advocate Designation for Mental Health Treatment to grant powers to another individual designated as your Patient Advocate. Your Patient Advocate has specific authority to make mental health decisions on your behalf. This authority is triggered, if and only if, you are unable to participate in your mental health decisions. The determination if you can participate in your mental health decisions will be made by your physician and mental health professional. This authorization is also intended to be a specific release of your mental health information to your Patient Advocate so that they can make a determination if they in fact are required to serve. You have the right to take back this designation and revoke it at any time provided that you are of sound mind, unless you have chosen to waive this right. The intended purpose of this Patient Advocate Designation for Mental Health Treatment is to address issues of your mental health treatment and your preferences. If at any time you or your Patient Advocate do not understand this Patient Advocate Designation for Mental Health Treatment, you should ask your lawyer to explain it. You should complete a Health Care Values History Form and provide a copy to your Patient Advocate.

I, [CLIENT NAME] (the “Patient”) of [CLIENT CITY], Michigan, being of sound mind, full age and under no duress or influence, do hereby make the following Patient Advocate Designation for Mental Health Treatment pursuant to MCL 700.5506.

1. ***Designation of Patient Advocate.*** I hereby designate [PA NAME], of [PA CITY], Michigan, as my Patient Advocate for Mental Health Treatment to exercise powers concerning my mental health care and to make mental health treatment decisions for me. If [PA NAME] does not accept, resigns, is incapacitated, dies, or is otherwise unwilling to act, I appoint [SPA 1 NAME] of [SPA 1 CITY], Michigan, as my Successor Patient Advocate for Mental Health Treatment. If [SPA 1 NAME] does not accept, resigns, is incapacitated, dies, or is otherwise unwilling to act, I appoint [SPA 2 NAME] of [SPA 2 CITY], Michigan, as my Successor Patient Advocate/

If my Patient Advocate is unable to act after a reasonable effort has been made to contact that person, my Successor Patient Advocate is authorized to act until my Patient Advocate becomes available.

2. ***Effective Date and Durability.*** This document is intended to create a Power of Attorney pursuant to MCL 700.5506 that may be exercised only when I am unable to participate in mental health treatment decisions. My physician and a mental health professional, after examining me, shall determine whether I am able to participate in mental health treatment decisions. I wish the mental health professional to be (*select one*):

_____ A physician who is licensed to practice medicine or osteopathic medicine and surgery in Michigan.

_____ A licensed or limited licensed, psychologist practicing in Michigan.

_____ A registered professional nurse licensed to practice in Michigan.

_____ A social worker registered as a certified social worker, or after July 1, 2005, "a licensed master's social worker") licensed to practice in Michigan.

_____ A physician's assistant licensed to practice in Michigan.

_____ A licensed professional counselor under the Public Health Code.

I designate the following individual(s) to make this determination (name and professional):

Any determination that I am unable to participate in mental health treatment decisions, to do so must be in writing; made part of my mental health treatment records and reviewed at least annually. If I regain my ability to participate in mental health treatment decisions, my designation of a Patient Advocate for mental health treatment is suspended but may become effective again if I am subsequently determined to be unable to participate in medical decisions in accordance with the procedure set forth above. This Patient Advocate Designation for Mental Health Treatment shall not be affected by my disability and shall continue in effect until my death or until I revoke it in writing.

3. ***Powers of Patient Advocate.*** My Patient Advocate for Mental Health Treatment shall be considered my "Personal Representative" for purposes of the Privacy Rule issued by the U.S. Department of Health and Human Services and required by the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and may have full access to my medical and mental health records, including any psychotherapy notes. I grant to my Patient Advocate full power and authority to make decisions for me regarding my mental health treatment and care. I intend for my Patient Advocate to have the same authority to exercise all of my rights as a citizen, including, but not limited to, the right of liberty and self-determination that I have while I am competent, including those specified in the Michigan Mental Health Code, MCL 330.1100 et seq.

In exercising this authority, my Patient Advocate shall follow my expressed wishes, either written or oral, regarding my mental health treatment. In making any decision, my Patient Advocate should first try to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Patient Advocate cannot determine the choice I would want based on my past written or oral statements, or if this Patient Advocate Designation for Mental Health Treatment does not contemplate the particular mental health treatment decision with which my Patient Advocate is faced, then my Patient Advocate shall choose for me

based on what my Patient Advocate believes to be in my best interest and is the least restrictive treatment intervention in accordance with my diagnosis and severity of symptoms, and in accordance with Michigan's Mental Health Code, MCL §330.1100 et seq.

Unless specifically limited by me, by either written or oral statements, my Patient Advocate shall have the power to obtain, consent to, and/or refuse treatment on my behalf to ensure I receive proper and adequate mental health care and treatment that is in my best interest and is the least restrictive treatment intervention, including arranging appropriate residential placement, and making payment arrangements to secure the necessary treatment. My Patient Advocate for Mental Health Treatment shall also work with any Representative Payee for any government benefits that I may be entitled to, Conservator, Guardian of my Estate, Agent named under a Durable Power of Attorney, Patient Advocate for medical decisions, or Trustee of a trust established for my benefit, if necessary to fulfill these responsibilities identified herein.

4. ***Specific Grants of Authority.*** My Patient Advocate shall have the following authority regarding my mental health treatment (*Optional*):

a. ***Inpatient Psychiatric Hospitalization.*** My Patient Advocate (*select one*):

_____ shall

_____ shall not

have the power to consent to inpatient psychiatric hospitalization and treatment, if it is in my best interest and is the least restrictive treatment, to protect my safety and/or the safety of others, and if in accordance with the civil admission and discharge procedures set forth in Chapter Four of the Michigan Mental Health Code.

However, if I am hospitalized as a formal voluntary patient under an application executed by my Patient Advocate, I retain the right to terminate the hospitalization in accordance with MCL §330.1419.

b. ***Forced Administration of Psychiatric Medications.*** My Patient Advocate (*select one*):

_____ shall

_____ shall not

have the power to consent to forced administration of psychiatric medications, if it is in my best interest and is the least restrictive treatment to protect my safety and/or the safety of others.

c. ***Electroconvulsive Therapy.*** My Patient Advocate (*select one*):

_____ shall

_____ shall not

have the power to consent to electroconvulsive therapy, or a procedure intended to produce convulsions or coma, in accordance with MCL § 330.1717 of the Michigan Mental Health Code, if it is in my best interest and is the least restrictive treatment to protect my safety and/or the safety of others.

5. ***Waiver of Right to Revoke.*** Regarding the revocation of this Patient Advocate Designation for Mental Health treatment (*select one*):

_____ I do not waive the right to revoke the powers granted in this Patient Advocate Designation regarding mental health treatment decisions. The powers granted to my Patient Advocate to make mental health treatment decisions will be terminated upon the communication of my intent to revoke.

_____ I do waive the right to revoke the powers granted in this Patient Advocate Designation regarding mental health treatment decisions. This waiver does not affect the rights afforded to me to terminate formal voluntary hospitalization under MCL §330.1419. Furthermore, if I communicate at a later time that I wish to revoke this Patient Advocate Designation for mental health treatment while I am deemed unable to participate in decisions regarding mental health treatment, and I am receiving mental health treatment at that time, mental health treatment shall not continue for more than thirty (30) days. I understand that upon termination of the mental health treatment after thirty (30) days, one of the following may occur:

- a. No further treatment will be necessary;
- b. Assistant outpatient treatment is ordered by a court of competent jurisdiction; or,
- c. Involuntary psychiatric hospitalization is ordered by a court of competent jurisdiction under Michigan Mental Health Code, MCL 330.1434 et seq.

6. ***Binding Effect on Mental Health Professionals.*** A mental health professional who provides mental health treatment to a patient shall comply with my wishes as expressed in writing or orally, or in this Patient Advocate Designation for Mental Health Treatment. However, I acknowledge that under MCL §700.5511(4), the mental health professional is not bound to follow that desire if one or more of the following apply:

- a. In the opinion of the mental health professional, compliance is not consistent with generally accepted community practice standards of treatment;
- b. The treatment requested is not reasonably available;
- c. Compliance is not consistent with applicable law;

- d. Compliance is not consistent with court ordered treatment; or,
- e. In the opinion of the mental health professional, there is a psychiatric emergency endangering my life or another individual and compliance is not appropriate under the circumstances.

7. **Conflicts with Patient Advocate for Medical Treatment.** I (select one) _____ have/ _____ have not previously executed a Patient Advocate Designation for Medical Treatment on _____ (date, if applicable).

If there is disagreement between my Patient Advocate for Mental Health Treatment and my Patient Advocate for Medical Care regarding authorization of treatment which affects both my medical status and mental health, instructions from the following shall receive priority (select one if applicable):

- _____ Patient Advocate for Mental Health Treatment, or
- _____ Patient Advocate for Medical Care

Furthermore, if a dispute arises as to whether the course of treatment which affects both my medical and mental health status is in my best interest, my Patient Advocate identified above shall obtain the advice from _____ to determine the course of treatment. If this conflict is not resolved, then my Patient Advocate for either Mental Health Treatment or Health Care reserves the right to petition the court for instructions.

8. **Nomination of Guardian.** If a guardian of my person is necessary, I nominate (select one)

- _____ Patient Advocate for Mental Health Treatment, or
- _____ Patient Advocate for Medical Care

to serve as my guardian. If this nomination conflicts with my Patient Advocate Designation for medical treatment decisions previously executed on _____, this nomination shall control.

9. **Third Party Reliance.** For the purpose of inducing any and all persons connected with the administration of my mental health care or the implementation of this Patient Advocate Designation for Mental Health Treatment, I represent, warrant and agree that if this document is revoked, modified or amended, I and my estate, heirs, successors and assigns will hold any person harmless from any loss suffered or liability incurred as a result of such person acting in good faith upon the instructions of the Patient Advocate prior to the receipt by such person of actual notice of such revocation, modification or amendment, provided such person's actions are not otherwise invalid or unenforceable.

10. **No Compensation.** My Patient Advocate shall not be entitled to compensation for services performed under this Patient Advocate Designation for Mental Health Treatment, but shall be entitled to reimbursement for actual and necessary expenses incurred as a result of

carrying out his/her authority, rights and responsibilities pursuant to this Patient Advocate Designation for Mental Health Treatment.

11. ***Revocation of Prior Patient Advocate Designations for Mental Health Treatment.*** I revoke any prior Patient Advocate Designations or Durable Powers of Attorney which relate to mental health care that I may have executed to the extent that, and only to the extent that, they grant powers and authority within the scope of the powers granted to the Patient Advocate appointed herein. Nothing in this paragraph shall be deemed to revoke any prior Patient Advocate Designations or Durable Powers of Attorney which relate to health or medical care previously executed by me. Nothing in this paragraph shall be deemed to revoke any portion of a certain Durable Power of Attorney executed by me on this date.

12. ***Separability.*** As required under MCL §700.5513, if a provision of this Patient Advocate Designation for Mental Health Treatment conflicts with the Michigan Mental Health Code, the Michigan Mental Health Code shall control. Furthermore, if any provision of this Patient Advocate Designation for Mental Health Treatment shall be declared invalid or unenforceable under applicable law, that provision shall not affect the other provisions hereof, and this Patient Advocate Designation for Mental Health Treatment shall be construed as if such invalid or unenforceable provision(s) were omitted.

13. ***Binding Effect on Subsequent Disability or Incapacity.*** This Patient Advocate Designation shall not be affected by any subsequent disability or incapacity that I may suffer and is intended to be fully binding, without prior court intervention or approval, to the fullest extent provided by MCL 700.5506. **I direct that this Patient Advocate Designation for Mental Health Treatment be made part of my mental health treatment record of the mental health professional providing treatment, the community mental health services program or hospital providing mental health services, and, if applicable, with the facility where I am located. This Patient Advocate Designation for Mental Health Treatment shall also be made part of my medical records, along with my Patient Advocate Designation for medical decisions, including with my attending physician, and the hospital where I am receiving treatment.**

14. ***Governing Law.*** This Patient Advocate Designation for Mental Health Treatment shall be subject to and governed by the laws of the State of Michigan. However, I intend for this Patient Advocate Designation for Mental Health Treatment to be honored in any jurisdiction where it is presented and for such jurisdiction to refer to Michigan law to interpret and determine its validity and enforceability.

15. ***Photographic Copies.*** Photographic or other facsimile reproductions of this executed Patient Advocate Designation for Mental Health Treatment may be made and delivered by my Patient Advocate, and may be relied upon by any person to the same extent as though the copy were an original. Anyone who acts in reliance upon any representation or certificate of my Patient Advocate, or upon a reproduction of this Patient Advocate Designation for Mental Health Treatment, shall not be liable for permitting my Patient Advocate to perform any act pursuant to this power.

IN WITNESS WHEREOF, I have signed and delivered this *Patient Advocate Designation for Mental Health Treatment* this _____ day of _____, 2006.

[CLIENT NAME]

AFFIDAVIT of WITNESSES

I declare that [CLIENT NAME] (the “Patient”) signed or acknowledged this Patient Advocate Designation for Mental Health Treatment in my presence, and that the Patient appears to be of sound mind and under no duress, fraud or undue influence. I am at least eighteen (18) years of age and I am not the person appointed as Patient Advocate by this Patient Advocate Designation for Mental Health Treatment, nor am I the Patient’s physician, an employee of the Patient’s life or health insurance provider, or an employee of the health care facility or home for the aged where the Patient resides, or of a community mental health services program or hospital that is providing mental health services to the Patient. Further, I declare that I am not the Patient’s spouse, parent, child, grandchild, sibling, or presumptive heir; and, to the best of my knowledge, I am not entitled to any part of the Patient’s estate under a Will now existing or by operation of law.

WITNESSES:

Signature

Name

Address

Signature

Name

Address

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

On _____, 2006, I signed a *Patient Advocate Designation for Mental Health Treatment* naming [PA NAME] as my Patient Advocate and [SPA 1 NAME] or [SPA 2 NAME] as Successor Patient Advocate. It is important for them to be fully aware of my mental health situation so they can make mental health treatment decisions affairs on my behalf if necessary. For that reason, I sign this authorization.

In accordance with the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), I authorize _____, or any other physician or mental health professional to release to my nominated Patient Advocate and/or Successor Patient Advocate any protected health information for the purpose of determining whether I am unable to participate in mental health treatment decisions.

This authorization expires upon notice that my Patient Advocate Designation for Mental Health Treatment noted above has been revoked or upon notice that I have specifically revoked this authorization. Otherwise, the authorization continues to be valid.

I recognize that I have a legal right to revoke this authorization at any time in writing by sending a notice to that effect to my treating physician or mental health professional.

I recognize that whether or not I sign this authorization has no effect on treatment, payment, enrollment or eligibility for benefits.

I recognize that any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected under HIPAA.

Dated: _____
[CLIENT NAME]

NOTICE TO PATIENT ADVOCATE

The intended purpose of this *Patient Advocate Designation for Mental Health Treatment* is to address issues related to the Patient's mental health. As the Patient Advocate you are given power under this Patient Advocate Designation to make decisions regarding mental health treatment according with the terms of this Patient Advocate Designation. The Patient directs use your best effort to fulfill your duties under this Patient Advocate Designation consistent the Patient's "Values History Form." The Patient desires that you have a copy of such form. If you do not have a copy of this form please request one from the Patient's attorney who has been authorized to provide you a copy.

This authority is triggered, if and only if, one physician and one mental health professional determines the Patient is unable to participate in these mental health treatment decisions. The Patient also specifically authorized the release of the Patient's mental health treatment information to you so that you may obtain information from the physician and mental health professional and determine if you are required to serve. If at any time you do not understand this *Patient Advocate Designation for Mental Health Treatment* or your duties under it, you should ask a lawyer to explain it to you. The Patient authorized you to contact, confer with and hire the Patient's attorney who drafted the Patient Advocate Designation for Mental Health Treatment even if the information communicated between you and the Patient's Attorney would otherwise be confidential or privileged.

By law, you cannot receive compensation for executing your duties as Patient Advocate, from the individual's funds or from any other third parties. You may, however receive reimbursement for actual and necessary expenses paid out of your own funds on behalf of the individual in carrying out your duties and responsibilities as Patient Advocate (e.g., copying fees for mental health treatment records, patient co-pays).

Please also note that although the guidelines and restrictions, as listed in the *Acceptance of Patient Advocate* may not be applicable to your authority or powers granted as a Patient Advocate for Mental Health Treatment, these guidelines and restrictions must be provided to you by law under MCL § 700.5507(4).

Drafted by:
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ACCEPTANCE OF PATIENT ADVOCATE DESIGNATION

I, [PA NAME], of [PA CITY], Michigan, acknowledge that I have received a copy of the attached Patient Advocate Designation for Mental Health Treatment and do hereby agree to serve as the Patient Advocate for [CLIENT NAME] (the "Patient") in accordance with both the terms and conditions set forth in the Patient Advocate Designation for Mental Health Treatment and the following guidelines and restrictions:

1. This patient advocate designation is not effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift the authority remains exercisable after the patient's death.

2. A Patient Advocate shall not exercise powers concerning the Patient's care, custody, and medical or mental health treatment that the Patient, if the Patient were able to participate in the decision, could not have exercised on his or her own behalf.

3. This Designation cannot be used to make a medical or mental health treatment decision to withhold or withdraw treatment from a Patient who is pregnant that would result in the pregnant Patient's death.

4. A Patient Advocate may decide to withhold or withdraw treatment that would allow the Patient to die only if the Patient has expressed in a clear and convincing manner that the Patient Advocate is authorized to make such a decision and that the Patient acknowledges that such a decision could or would allow the Patient's death.

5. A Patient Advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a Patient Advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

6. A Patient Advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the Patient and shall act consistent with the Patient's best interests. The known desires of the Patient expressed or evidenced while the Patient is able to participate in mental health treatment decisions are presumed to be in the Patient's best interests.

7. The Patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.

8. The Patient may waive his or her right to revoke this Patient Advocate Designation as to the power to make mental health treatment decisions, and if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

9. A Patient Advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

10. A Patient admitted to a health facility or agency has the rights enumerated in MCL 333.20201.

If I am unable to act after reasonable efforts to contact me, I delegate my authority to the Successor Patient Advocate that the Patient has designated, in the order designated. The Successor Patient Advocate is authorized to act until I become available. If I act as Successor, I acknowledge that my authority ends when any higher-ranking patient advocate becomes available.

IN WITNESS WHEREOF, I have executed this *Acceptance of Patient Advocate Designation for Mental Health Treatment* for [CLIENT NAME] this ____ day of _____, 2006.

[PA NAME]

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

On _____, 2006, I signed an *Acceptance of Patient Advocate Designation for Mental Health Treatment* to act as Patient Advocate for [CLIENT NAME].

I therefore authorize any covered entity under HIPAA to disclose protected health information about me for the purpose of determining my capacity to act as Patient Advocate. I hereby voluntarily waive any physician-patient privilege or psychiatrist-patient privilege that may exist in my favor, and I hereby authorize physicians to examine me and disclose my physical or mental condition in order to determine my incapacity or capacity for purposes of acting in the role of agent according to the terms of this document.

This authorization expires upon notice that the *Patient Advocate Designation for Mental Health Treatment* executed by _____ has been revoked or upon notice that I have specifically revoked this authorization. Otherwise, the authorization continues to be valid.

I recognize that I have a legal right to revoke this authorization at any time in writing by sending a notice to that effect to my treating physician or mental health professional.

I recognize that whether or not I sign this authorization has no effect on treatment, payment, enrollment or eligibility for benefits.

I recognize that any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected under HIPAA.

Dated: _____

[PA NAME]

NOTICE TO PATIENT ADVOCATE

The intended purpose of this Patient Advocate Designation for Mental Health Treatment is to address issues related to the Patient's mental health. As the Patient Advocate you are given power under this Patient Advocate Designation to make decisions regarding mental health treatment according with the terms of this Patient Advocate Designation. The Patient directs use your best effort to fulfill your duties under this Patient Advocate Designation consistent the Patient's "Mental Health Care Values History Form." The Patient desires that you have a copy of such form. If you do not have a copy of this form please request one from the Patient's attorney who has been authorized to provide you a copy.

This authority is triggered, if and only if, one physician and one mental health professional determines the Patient is unable to participate in these mental health treatment decisions. The Patient also specifically authorized the release of the Patient's mental health treatment information to you so that you may obtain information from the physician and mental health professional and determine if you are required to serve. If at any time you do not understand this Patient Advocate Designation for Mental Health Treatment or your duties under it, you should ask a lawyer to explain it to you. The Patient authorized you to contact, confer with and hire the Patient's attorney who drafted the Patient Advocate Designation for Mental Health Treatment even if the information communicated between you and the Patient's Attorney would otherwise be confidential or privileged.

By law, you cannot receive compensation for executing your duties as Patient Advocate, from the individual's funds or from any other third parties. You may, however receive reimbursement for actual and necessary expenses paid out of your own funds on behalf of the individual in carrying out your duties and responsibilities as Patient Advocate (e.g., copying fees for mental health treatment records, patient co-pays).

Please also note that although the guidelines and restrictions, as listed in the *Acceptance of Patient Advocate* may not be applicable to your authority or powers granted as a Patient Advocate for Mental Health Treatment, these guidelines and restrictions must be provided to you by law under MCL § 700.5507(4).

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ACCEPTANCE OF SUCCESSOR PATIENT ADVOCATE DESIGNATION

I, [SPA 1 NAME], of [SPA 1 CITY], Michigan, acknowledge that I have received a copy of the attached Patient Advocate Designation for Mental Health Treatment and do hereby agree to serve as the Patient Advocate for [CLIENT NAME] (the "Patient") in accordance with both the terms and conditions set forth in the Patient Advocate Designation for Mental Health Treatment and the following guidelines and restrictions:

1. This patient advocate designation is not effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift the authority remains exercisable after the patient's death.

2. A Patient Advocate shall not exercise powers concerning the Patient's care, custody, and medical or mental health treatment that the Patient, if the Patient were able to participate in the decision, could not have exercised on his or her own behalf.

3. This Designation cannot be used to make a medical or mental health treatment decision to withhold or withdraw treatment from a Patient who is pregnant that would result in the pregnant Patient's death.

4. A Patient Advocate may decide to withhold or withdraw treatment that would allow the Patient to die only if the Patient has expressed in a clear and convincing manner that the Patient Advocate is authorized to make such a decision and that the Patient acknowledges that such a decision could or would allow the Patient's death.

5. A Patient Advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a Patient Advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

6. A Patient Advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the Patient and shall act consistent with the Patient's best interests. The known desires of the Patient expressed or evidenced while the Patient is able to participate in mental health treatment decisions are presumed to be in the Patient's best interests.

7. The Patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.

8. The Patient may waive his or her right to revoke this Patient Advocate Designation as to the power to make mental health treatment decisions, and if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

9. A Patient Advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

10. A Patient admitted to a health facility or agency has the rights enumerated in MCL 333.20201.

If I am unable to act after reasonable efforts to contact me, I delegate my authority to the Successor Patient Advocate that the Patient has designated, in the order designated. The Successor Patient Advocate is authorized to act until I become available. If I act as Successor, I acknowledge that my authority ends when any higher-ranking patient advocate becomes available.

IN WITNESS WHEREOF, I have executed this *Acceptance of Patient Advocate Designation for Mental Health Treatment* for [CLIENT NAME] this ____ day of _____, 2006.

[SPA 1 NAME]

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

On _____, 2006, I signed an *Acceptance of Patient Advocate Designation for Mental Health Treatment* to act as Successor Patient Advocate for [CLIENT NAME].

I therefore authorize any covered entity under HIPAA to disclose protected health information about me for the purpose of determining my capacity to act as Successor Patient Advocate. I hereby voluntarily waive any physician-patient privilege or psychiatrist-patient privilege that may exist in my favor, and I hereby authorize physicians to examine me and disclose my physical or mental condition in order to determine my incapacity or capacity for purposes of acting in the role of agent according to the terms of this document.

This authorization expires upon notice that the Patient Advocate Designation for Mental Health Treatment executed by _____ has been revoked or upon notice that I have specifically revoked this authorization. Otherwise, the authorization continues to be valid.

I recognize that I have a legal right to revoke this authorization at any time in writing by sending a notice to that effect to my treating physician or mental health professional.

I recognize that whether or not I sign this authorization has no effect on treatment, payment, enrollment or eligibility for benefits.

I recognize that any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected under HIPAA.

Dated: _____

[SPA 1 NAME]

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Please also note that although the guidelines and restrictions, as listed in the *Acceptance of Patient Advocate* may not be applicable to your authority or powers granted as a Patient Advocate for Mental Health Treatment, these guidelines and restrictions must be provided to you by law under MCL § 700.5507(4).

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ACCEPTANCE OF SUCCESSOR PATIENT ADVOCATE DESIGNATION

I, [SPA 2 NAME], of [SPA 2 CITY], Michigan, acknowledge that I have received a copy of the attached Patient Advocate Designation for Mental Health Treatment and do hereby agree to serve as the Patient Advocate for [CLIENT NAME] (the "Patient") in accordance with both the terms and conditions set forth in the Patient Advocate Designation for Mental Health Treatment and the following guidelines and restrictions:

1. This patient advocate designation is not effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift the authority remains exercisable after the patient's death.

2. A Patient Advocate shall not exercise powers concerning the Patient's care, custody, and medical or mental health treatment that the Patient, if the Patient were able to participate in the decision, could not have exercised on his or her own behalf.

3. This Designation cannot be used to make a medical or mental health treatment decision to withhold or withdraw treatment from a Patient who is pregnant that would result in the pregnant Patient's death.

4. A Patient Advocate may decide to withhold or withdraw treatment that would allow the Patient to die only if the Patient has expressed in a clear and convincing manner that the Patient Advocate is authorized to make such a decision and that the Patient acknowledges that such a decision could or would allow the Patient's death.

5. A Patient Advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a Patient Advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

6. A Patient Advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the Patient and shall act consistent with the Patient's best interests. The known desires of the Patient expressed or evidenced while the Patient is able to participate in mental health treatment decisions are presumed to be in the Patient's best interests.

7. The Patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.

8. The Patient may waive his or her right to revoke this Patient Advocate Designation as to the power to make mental health treatment decisions, and if such a waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

9. A Patient Advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

10. A Patient admitted to a health facility or agency has the rights enumerated in MCL 333.20201.

If I am unable to act after reasonable efforts to contact me, I delegate my authority to the Successor Patient Advocate that the Patient has designated, in the order designated. The Successor Patient Advocate is authorized to act until I become available. If I act as Successor, I acknowledge that my authority ends when any higher-ranking patient advocate becomes available.

IN WITNESS WHEREOF, I have executed this *Acceptance of Patient Advocate Designation for Mental Health Treatment* for [CLIENT NAME] this ____ day of _____, 2006.

[SPA 2 NAME]

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

On _____, 2006, I signed an *Acceptance of Patient Advocate Designation for Mental Health Treatment* to act as Successor Patient Advocate for [CLIENT NAME].

I therefore authorize any covered entity under HIPAA to disclose protected health information about me for the purpose of determining my capacity to act as Successor Patient Advocate. I hereby voluntarily waive any physician-patient privilege or psychiatrist-patient privilege that may exist in my favor, and I hereby authorize physicians to examine me and disclose my physical or mental condition in order to determine my incapacity or capacity for purposes of acting in the role of agent according to the terms of this document.

This authorization expires upon notice that the Patient Advocate Designation for Mental Health Treatment executed by _____ has been revoked or upon notice that I have specifically revoked this authorization. Otherwise, the authorization continues to be valid.

I recognize that I have a legal right to revoke this authorization at any time in writing by sending a notice to that effect to my treating physician or mental health professional.

I recognize that whether or not I sign this authorization has no effect on treatment, payment, enrollment or eligibility for benefits.

I recognize that any information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected under HIPAA.

Dated: _____

[SPA 2 NAME]

DRAFT