PATIENT ADVOCATE DESIGNATION FOR MEDICAL AND MENTAL HEALTH TREATMENT FOR_[CLIENT NAME]

NOTICE TO PATIENT

As the "Patient" you are using this Patient Advocate Designation to grant powers to another individual designated as your Patient Advocate. Your Patient Advocate has specific authority to make medical and/or mental health decisions on your behalf. This authority is triggered, if and only if, you are unable to participate in your medical and/or mental health treatment decisions. This authorization is also intended to be a specific release of your medical and/or 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 specifically chosen to waive your right to revoke the powers related to mental health treatment. The intended purpose of this Patient Advocate Designation is to address issues including your medical decisions and "end of life" care, and mental health decisions. If at any time you or your Patient Advocate do not understand this Patient Advocate Designation, 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 pursuant to MCL 700.5506 and hereby expressly revoke any and all prior Patient Advocate Designations and/or Living Wills which I may have created.

A. PATIENT ADVOCATE DESIGNATION FOR MEDICAL TREATMENT

1. ***Designation of Patient Advocate***. I hereby designate my [PA RELATION], [PA NAME], of [PA CITY], as my Patient Advocate to exercise powers concerning my care and custody and to make medical treatment decisions for me.

2. ***Designation of Successor Patient Advocate***. If [PA NAME], the Patient Advocate I have named in Paragraph 1, is unable or unwilling to serve as my Patient Advocate, or becomes incapacitated, resigns or is removed, or is my spouse and an action for separate maintenance, annulment or divorce is filed, I hereby designate my [SPA 1 RELATION], [SPA 1 NAME], of [SPA 1 CITY], Michigan, to act as my Successor Patient Advocate. If [SPA 1 NAME] does not accept, resigns, is incapacitated, dies, is removed, or is otherwise unwilling to act, or is my spouse and an action for separate maintenance, annulment or divorce is filed, I hereby designate my [SPA 2 RELATION], [SPA 2 NAME], of [SPA 2 CITY], Michigan, to act 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.

Please refer to page 14 for contact information of my nominated Patient Advocate(s) and Successor Patient Advocate(s).

3. ***Effective Date and Durability***. This portion of the 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 medical treatment decisions. My attending physician and one other physician or licensed psychologist, after examining me, shall determine whether I am able to participate in medical treatment decisions.

Any determination that I am unable to participate in medical decisions must be in writing, made part of my medical record and reviewed at least annually. If I regain my ability to participate in medical treatment decisions, my designation of a Patient Advocate 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 in this paragraph. This Patient Advocate Designation shall not be affected by my disability and shall continue in effect until my death, with the exception of the authority granted in Section 4(g), or until I revoke it in writing.

4. ***Powers of Patient Advocate for Medical Treatment*** . My Patient Advocate 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"). I grant to my Patient Advocate full power and authority to make decisions for me regarding my health care. I intend for my Patient Advocate to have the same authority to exercise my rights of liberty and self-determination that I have while I am competent. In exercising this authority, my Patient Advocate shall follow my expressed wishes, either written or oral, regarding my medical 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 written or oral statements, then my Patient Advocate shall choose for me based on what my Patient Advocate believes to be in my best interests.

If this Patient Advocate Designation does not contemplate the particular treatment decision with which my Patient Advocate is faced, then I direct my Patient Advocate to use my Patient Advocate's best judgment about what my wishes would be, using as a guide the preferences expressed in this Patient Advocate Designation and any other treatment choices I have made, or preferences I have stated while competent that are not reflected in this Patient Advocate Designation.

My Patient Advocate has the power and authority to act in a manner different from that prescribed in this Patient Advocate Designation if my physician advises my Patient Advocate of a medical fact or circumstance, or states a medical opinion, that my Patient Advocate believes would cause me to change my mind about the instructions I have expressed in this Patient

Advocate Designation. Unless specifically limited by this section, my Patient Advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of me, including without limitation:

a) To give or withhold consent to all types of medical care, treatment, surgery, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function; to revoke, withdraw, modify or change consent to medical treatment, surgery, diagnostic procedures, medication, or the use of mechanical or procedures that affect any bodily function that I or my Patient Advocate may have previously allowed or consented to or which may have been implemented due to emergency conditions;

b) To summon paramedics or other emergency medical personnel and seek emergency treatment for me, as my Patient Advocate shall deem appropriate;

c) To request, review and receive any information, verbal or written, regarding my personal affairs or my physical or mental health, including medical and hospital records, and to execute any releases or other documents that may be required to obtain this information, to waive any physician/patient privilege, and to disclose my medical and other personal information to others;

d) To authorize my admission to any hospital, hospice, convalescent care or nursing home care, residential care, assisted living, or similar facility or service; and to revoke, withdraw, modify or change consent (even against medical advice) to my hospitalization, hospice, convalescent care, nursing home care, residential care or assisted living which I or my Patient Advocate may have previously allowed;

e) To employ and discharge physicians, psychiatrists, dentists, nurses, therapists, domestic help and other professionals as my Patient Advocate may deem necessary for my physical, mental and emotional well being; and to pay them, or any of them, reasonable compensation;

f) To consent or refuse consent to the administration of pain-relieving drugs of any type, or other surgical or medical procedures calculated to relieve my pain, including unconventional pain relief therapies which my Patient Advocate believes may be helpful, even though their use may lead to permanent physical damage, addiction or even hasten the moment of (but not intentionally cause) my death;

g) To make anatomical gifts of my body or of any part thereof which will take effect at my death, as well as the power to donate all or any of my eyes, tissues or organs at the time of my death, to such persons and organizations and in such manner as my Patient Advocate shall deem

appropriate and to execute such papers, and incur such expenses on behalf of my estate as shall be necessary, appropriate, incidental or convenient in connection with such gifts. This power shall also include the power to authorize the release of my medical records and the power to authorize or refuse an autopsy of my body following my death. If I have indicated the manner in which such gifts are to be made, I request that my Patient Advocate carry out my wishes to the extent deemed practical by my Patient Advocate;

h) To execute any documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice" or specifically request and concur with the writing of a "No Code" (DO NOT RESUSCITATE) order by the attending or treating physician, as well as any necessary waivers of or releases from liability required by the hospitals or physicians to implement my wishes regarding medical treatment or nontreatment; and

i) To consult counsel and to take appropriate legal action, if necessary, in my Patient Advocate's discretion, to enforce and carry out my wishes regarding medical treatment or nontreatment.

5. ***Life Sustaining Treatment: Directive to Withhold or Withdraw Treatment***. I do not wish to receive or to continue to receive medical treatment (i) that will only postpone the moment of my death from an incurable and terminal condition or (ii) that will prolong an irreversible coma or (iii) if I have irreversible brain damage. For purposes of this Patient Advocate Designation, (i) "terminal condition" means a condition that is reasonably expected to result in my death within six (6) months regardless of the medical treatment that I may receive; and (ii) "irreversible coma" means a permanent loss of consciousness from which there is no reasonable possibility that I may return to a cognitive (capable of understanding) and sapient (capable of reasoning) life, and shall include, but shall not be limited to, a persistent vegetative state; and (iii) "irreversible brain damage" means a permanent condition caused by accident or disease which makes me unable to recognize people and/or understand my surroundings and environment to the point where my quality of life has significantly deteriorated. By "medical treatment," I mean any diagnostic or therapeutic procedure or test, whether invasive or not, including by way of illustration only, surgery, drugs, renal dialysis, artificial feeding and hydration (including, for example, parenteral feeding, intravenous feeding and endotracheal or nasogastric tube use), cardiopulmonary resuscitation, respirators or ventilators, and any other experimental or non-experimental procedure, therapy or device.

If two (2) licensed and qualified physicians who are familiar with my condition have diagnosed and noted in my medical records that I am unable to give informed consent to medical treatment that is proposed or available for my condition and (i) my condition is terminal as defined above, or (ii) I am in an irreversible coma as defined above, or (iii) I have irreversible brain damage as defined above, then, in such event, I request that the appropriate individuals, health care providers and my Patient Advocate honor the following requests:

a) Medical treatment (other than artificial feeding and hydration) which will only postpone the moment of my death or prolong my irreversible coma (whether or not such medical treatment is directed toward my terminal condition) should be withheld or, if previously begun, withdrawn.

b) Any attending physician of mine should write or cause to be issued an effective and enforceable "No Code" or "Do Not Resuscitate" order.

c) My Patient Advocate should sign on my behalf any and all documents he or she may deem necessary and proper to implement the instructions contained herein, including without limitation, waivers or releases of liability required by any health care provider and consents to "No Code" or "Do Not Resuscitate" orders.

d) I should be given or administered whatever is appropriate to keep me as comfortable and free of pain as is reasonably possible, including without limitation pain-relieving drugs of any kind, surgical and/or medical procedures calculated to relieve my pain, and unconventional pain-relief therapies which my Patient Advocate believes may be helpful, even though such drugs or procedures may lead to permanent physical damage or addiction, or hasten the moment of my death.

e) If, in addition to the general circumstances described above, either

(i) I am in an "irreversible coma" (as defined above) and such condition has existed for thirty (30) days or more after withdrawal of "life support" devices, such as respirators or ventilators (without limitation) *or*,

(ii) it is no longer possible to nourish and hydrate me without severe discomfort because of my "terminal condition" as defined above,

and the two physicians described above conclude that

(i) nourishment and hydration will not improve my physical condition and

(ii) I will not experience pain as a result of the withdrawal of nourishment and hydration,

then procedures to provide me with nourishment and hydration (including, without limitation, all forms of intravenous, parenteral and tube feeding and misting) shall be withheld, or, if previously instituted, withdrawn.

In the absence of my ability to give directions regarding the medical treatment or the use of such life-sustaining procedures, it is my intention that this directive be honored by my Patient Advocate, my family, my physician and nurses, and the medical facility as a final expression of my legal right to refuse or withdraw from medical or surgical treatment or care. I fully accept

and acknowledge the consequences, *including my own death*, that may result from authorizing my Patient Advocate to withhold or withdraw treatment that would allow me to die. I understand the full import of this directive, I am emotionally and mentally competent to make this directive and I authorize my Patient Advocate to do any and all things which shall be necessary in order to carry out and effect this directive.

B. PATIENT ADVOCATE DESIGNATION FOR MENTAL HEALTH TREATMENT

6. ***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 the individual nominated as my Patient Advocate 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 for Mental Health Treatment.

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.

7. ***Effective Date and Durability.*** This portion of 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 (until July 1, 2005, but "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.

8. ***Powers of Patient Advocate for Mental Health Treatment***. 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, 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.

9. ***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.

10. ***Waiver of Right to Revoke***. Regarding the revocation of this portion of my 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. Assisted 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.

11. ***Conflicts with Patient Advocate for Medical Treatment***. 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.

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C. ADDITIONAL PROVISIONS

12. ***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.

13. ***Binding Effect on Medical and Mental Health Professionals***. 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.

A medical professional who provides medical treatment to me shall comply with my wishes as expressed written or orally, or in this Patient Advocate Designation for Medical and Mental Health Treatment

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 the life of my life or another individual and compliance is not appropriate under the circumstances.

14. ***Third Party Reliance***. For the purpose of inducing any and all persons connected with the administration of my medical or mental health care, or the implementation of this Patient Advocate Designation, 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.

15. ***No Compensation***. My Patient Advocate shall not be entitled to compensation for services performed under this Patient Advocate Designation, 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.

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

17. ***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 Medical and Mental Health treatment be made part of my medical record with my attending physician, and, if applicable, with the facility where I am located. In addition, I direct that this Patient Advocate Designation 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.**

MY ATTORNEY MAY REPRESENT MY PATIENT ADVOCATE

My attorney who drafted this Patient Advocate Designation may advise and represent my Patient Advocate regarding its use, if my attorney and my Patient Advocate so agree. I understand that my Patient Advocate and I have potentially conflicting interests, because I might disagree with some actions my Patient Advocate might take because of my medical condition. However, to give my Patient Advocate the advantage of my attorney's services and knowledge of my affairs, I am waiving this conflict of interest acknowledging that my Patient Advocate cannot act until, and only when two (2) doctors certify I am unable to participate in medical treatment decisions. I also authorize my attorney in my attorney's discretion to communicate with my Patient Advocate regarding any aspect of my affairs directly related to the document, regardless of whether my attorney represents my Patient Advocate and even if the information communicated would otherwise be confidential or privileged.

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

_____
[CLIENT NAME]

AFFIDAVIT of WITNESSES

I declare that [CLIENT NAME] (the "Patient") signed or acknowledged this Patient Advocate Designation 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, 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	Signature
_____	_____
Name	Name
_____	_____
Address	Address
_____	_____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

On _____, 2006, I signed a *Patient Advocate Designation for Medical and 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 medical care treatment decisions.

This authorization expires upon notice that my *Patient Advocate Designation for Medical and 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 to release protected health information at any time in writing by sending a notice to that effect to my treating physicians or mental health professionals.

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]

CONTACT INFORMATION

Patient Advocate(s) & Successor Patient Advocate(s):

Name of PA: [PA NAME]
Address:
Telephone Number:

Name of Successor PA: [SPA 1 NAME]
Address:
Telephone Number:

Name of Successor PA: [SPA 2 NAME]
Address:
Telephone Number:

Physician(s) and/or Other Health Care Providers:

Name:
Title:
Address:
Telephone Number:

Name:
Title:
Address:
Telephone Number:

NOTICE TO PATIENT ADVOCATE FOR MEDICAL TREATMENT

The intended purpose of this Patient Advocate Designation is to address issues of the Patient's "end of life" care. As the Patient Advocate you are given power under this Patient Advocate Designation to make medical decisions for the Patient's "end of life" care according with the terms of this Patient Advocate Designation. The Patient directs you to use your best effort to fulfill your duties under this Patient Advocate Designation consistent with the Patient's "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, two (2) doctors determine the Patient is unable to participate in these medical decisions. The Patient also specifically authorized the release of the Patient's medical information to you so that you may obtain information from these doctors and determine if you are required to serve. If at any time you do not understand this Patient Advocate Designation 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 even if the information communicated between you and the Patient's Attorney would otherwise be confidential or privileged.

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 FOR MEDICAL TREATMENT

I, [PA NAME], of [PA CITY], Michigan, acknowledge that I have received a copy of the attached Patient Advocate Designation for Medical and 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 Medical and 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 medical or 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 _____ this _____ day of _____, 2006.

_____

[PA NAME]

Authorization to Release Protected Health Information

On _____, 2006, I signed an *Acceptance of Patient Advocate Designation for Medical Treatment* to act as Patient Advocate to make medical treatment decisions 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 Medical and 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 FOR MEDICAL TREATMENT

The intended purpose of this Patient Advocate Designation is to address issues of the Patient's "end of life" care. As the Patient Advocate you are given power under this Patient Advocate Designation to make medical decisions for the Patient's "end of life" care according with the terms of this Patient Advocate Designation. The Patient directs you to use your best effort to fulfill your duties under this Patient Advocate Designation consistent with the Patient's "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, two (2) doctors determine the Patient is unable to participate in these medical decisions. The Patient also specifically authorized the release of the Patient's medical information to you so that you may obtain information from these doctors and determine if you are required to serve. If at any time you do not understand this Patient Advocate Designation 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 even if the information communicated between you and the Patient's Attorney would otherwise be confidential or privileged.

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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Telephone: (248) 731-3080

ACCEPTANCE OF SUCCESSOR PATIENT ADVOCATE DESIGNATION FOR MEDICAL TREATMENT

I, [SPA 1 NAME], of [SPA 1 CITY], Michigan, acknowledge that I have received a copy of the attached *Patient Advocate Designation for Medical and Mental Health Treatment* and do hereby agree to serve as the Successor Patient Advocate for [CLIENT NAME] (the "Patient") in accordance with both the terms and conditions set forth in the Patient Advocate Designation 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 medical or 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 [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 Medical Treatment* to act as Patient Advocate to make medical treatment decisions for [CLIENT NAME].

I therefore authorize any covered entity under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 ("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 Medical and 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]

ACCEPTANCE OF SUCCESSOR PATIENT ADVOCATE DESIGNATION FOR MEDICAL TREATMENT

I, [SPA 2 NAME], of [SPA 2 CITY], Michigan, acknowledge that I have received a copy of the attached *Patient Advocate Designation for Medical and Mental Health Treatment* and do hereby agree to serve as the Successor Patient Advocate for [CLIENT NAME] (the "Patient") in accordance with both the terms and conditions set forth in the Patient Advocate Designation 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 medical or 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 [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 Medical Treatment* to act as Patient Advocate to make medical treatment decisions for [CLIENT NAME].

I therefore authorize any covered entity under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 ("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 Medical and 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]

NOTICE TO PATIENT ADVOCATE FOR MENTAL HEALTH TREATMENT

The intended purpose of this *Patient Advocate Designation* is in part 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* 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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Telephone: (248) 731-3080

ACCEPTANCE OF PATIENT ADVOCATE DESIGNATION FOR MENTAL HEALTH TREATMENT

I, [PA NAME] **,** of [PA CITY], Michigan, acknowledge that I have received a copy of the attached *Patient Advocate Designation for Medical and Mental Health Treatment* and do hereby agree to serve as the Successor Patient Advocate for [CLIENT NAME] (the "Patient") in accordance with both the terms and conditions set forth in the Patient Advocate Designation 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 medical or 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 _____ 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 to make mental health treatment decisions for [CLIENT NAME].

I therefore authorize any covered entity under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 ("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 Medical 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 FOR MENTAL HEALTH TREATMENT

The intended purpose of this Patient Advocate Designation for Mental Health Treatment is in part 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).

Drafted by:
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Telephone: (248) 731-3080

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 Medical and 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 Medical and 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 medical or 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 Medical and 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 to make mental health treatment decisions for [CLIENT NAME].

I therefore authorize any covered entity under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 ("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 Medical and 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]

NOTICE TO PATIENT ADVOCATE FOR MENTAL HEALTH TREATMENT

The intended purpose of this Patient Advocate Designation for Mental Health Treatment is in part 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).

Drafted by:
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Bloomfield Hills, MI 48302-2082
Telephone: (248) 731-3080

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 Medical and 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 Medical and 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 medical or 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.

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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 Medical and 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 to make mental health treatment decisions for [CLIENT NAME].

I therefore authorize any covered entity under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 ("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 Medical and 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]