



Advance Directive for Mental Health Treatment



Maryland Department of Health and Mental Hygiene
Mental Hygiene Administration

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NOTICE: *This is an important legal document.
Before signing this document, you should know these important facts.*

Introduction

Maryland law gives the right to anyone 16 years of age and over to be involved in decisions about their mental health treatment. However, a parent or guardian of a person under the age of 18 years may authorize treatment, even over the objection of the minor. The law also notes that at times, some persons are unable to make treatment decisions. Maryland law states that you have the right to make decisions in advance, including mental health treatment decisions, through a process called advance directive. An advance directive can be used to state your treatment choice or can be used to name a health care agent, that is someone that will make health care decisions for you.

- A. If you are a person with a mental illness, this document provides you the chance to take part in a major way in your mental health care decisions when you are not able to. This document allows you to express your consent or refusal to medications for your mental illness and other health care decisions, including use of seclusion and restraints. Please know that Maryland law allows a health care provider to override your refusal for medication for a mental disorder in limited situations if you are involuntarily committed to a psychiatric hospital.
- B. This document may be completed by any individual 18 years of age and has not been determined to be not capable of making an informed decision. An advance directive may be oral or written. If written, it must be signed and dated. Two witnesses must also sign the document. The health care agent may not be a witness. And, at least one witness may not be a person who is knowingly entitled to benefit by your death, for example inherit money, insurance benefits. The witnesses must sign the document stating that the person making the directive is personally known to them and appears to be of sound mind.
- C. If you wish to guide your health care providers on what treatment you wish to have if you should become unable to give consent, and you **DO NOT WANT A HEALTH AGENT**, fill out the form titled “Advance Directive for Mental Health Treatment”. If you want an agent to make the choice for you, fill out the form

“Appointment of Health Care Agent”. You may fill out both forms if you want an agent to make the choices and you also want to assist in those choices. If the directive is made orally, it must be made in the company of your attending physician and one witness.

- D. You can also make an advance directive naming a person as your health care agent, to make mental health decisions when you are not able to do so. The agent must make choices in line with any desires you have expressed in this document, or if your wishes are not expressed and are not known by the agent, the agent must act in good faith in what he/she believes to be in the best interest for you. It is your job to inform the agent that the agent has been named in your advance directive, and to make sure he/she agrees to be your agent. It is important that your health care agent be informed about your mental illness and the decisions you have made in this form. It is highly recommended that you discuss the contents of this form with your family and close friends and your mental health providers.
- E. Maryland law does not allow a person to sign another adult into a psychiatric hospital. Therefore, a health care agent may not sign you into a psychiatric hospital.
- F. Maryland law allows giving a medication for the treatment of a mental disorder over the person’s expressed wishes, or placing a person in seclusion or restraints against the person’s expressed wishes, under certain conditions.

Advance Directive for Mental Health Treatment

I (*name*) _____, being an adult, and emotionally and mentally able to make this directive, willfully and freely complete this health care advance directive to be followed if it is determined by two physicians that I am not able as a result of a psychiatric or physical illness to assist in my health care treatment. (The second physician may not be involved in my treatment). It is my intent that care will be carried out despite my inability to make choices on my own behalf. In the event that a guardian or other decision-maker is chosen by a court to make health care choices for me, I intend this document to take priority over all other means of discovering my intent while able.

The usual symptoms of my identified mental disorder may include:

I direct my health care providers to follow my choices as set forth below:

Medications for treatment of my mental illness:

If I become unable to make informed choices for treatment of my mental illness, my wishes regarding medications are as follows:

I may be allergic to the following medications:

Medication

Reaction

_____	_____
_____	_____
_____	_____

The following medications have been helpful in the past and I would agree to them if prescribed:

Initial all that apply:

___ I agree to the performance of all tests and other means to identify or assess my mental health.

___ I agree to the performance of all tests and other means to check how well the medications are working and their effect on my body, i.e. blood tests.

___ I specifically do not agree with dispensing the following medications, or their own brand-name, trade name or generic equal.

Medication

Reason for not agreeing

_____	_____
_____	_____
_____	_____

___ I agree with dispensing all medications prescribed by my treating psychiatrist, unless listed above.

Admission to and continuation of Mental Health Services from a facility other than an inpatient hospital.

Check one

___ I do not have a preference about receiving mental health services from a facility or other provider than a psychiatric hospital, i.e., clinic, PRP, mobile treatment.

___ I agree to receive services from a facility, which is not a hospital.

____ I do not agree to receive mental health services from a provider or facility other than a hospital.

Conditions/ Limits: _____

Other Choices

If I am unable to make informed decisions about my mental health choices, my wishes regarding other information or options are listed below:

Release of Records

I authorize the release of (check one):

- ____ any and all mental health records
____ the following mental health record / records of the following providers:

to: _____

(name of person records may be released to)

Appointment of Health Care Agent

*Cross through this page if you do not want to appoint
a health care agent to make decisions for you.*

I select the following person as my agent to make health care choices for me:

Name _____

Address _____

Work Number _____ Home Number _____

If this agent is unable, unwilling, or elsewhere engaged to act as my agent, then I
select the following person to act in this role:

Name: _____

Address _____

Work Number _____ Home Number _____

My agent has full power and right to make health care choices for me:

____ Just in regards to the instructions above.

____ If my wishes are not expressed above, and my wishes are not otherwise
known to my agent, or if my wishes are unknown or unclear, my agent is
to make health care choices for me with my best interest in mind, to be
determined by my agent after reviewing the benefits, burdens, risks that
might result from a given treatment or course of treatment, or from the
withholding or withdrawal of a treatment or course of treatment.

The authority of my agent is subject to the following conditions and limits:

My agent has full power and right to:

1. Request, receive and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and the right to disclose this information.
2. Employ and release my health care providers.
3. Approve my admission to or release from any facility (other than psychiatric hospital or unit), nursing home, adult home or other supervised housing or medical care facility.

Check one:

My agent's powers and rights become active:

____ when my attending physician and a second physician decide that I am unable to make well-versed choices regarding my health care;

OR

____ When this document is signed.

My agent shall not be responsible for costs of care based just on this agreement

SIGNATURES

By signing below, I indicate I am emotionally and mentally competent to make this Advance Directive.

Date

Signature

The above named person signed or acknowledged signing this advance directive in my company and based upon my personal study appears to be a capable person.

Witness name

Witness signature

Witness name

Witness signature