

**CONSENT TO AUTHORIZE ADVOCACY AND
RELEASE OF INFORMATION**

I, _____, hereby authorize
_____ Schools to release/exchange information with my
parents, _____,
which pertains to my school program and placement. I also wish that my
parents be invited to any and all meetings about me, and I do not want any
decisions made without their input. If the schools have any documents I
need to sign, my parents must sign first, before I will sign. This
authorization, unless otherwise revoked by me, is intended to remain in
effect for the duration of time I receive special education services or until
my twenty-seventh birthday, which ever comes first.

(name)

(date)

**DESIGNATION FOR PATIENT ADVOCATE
FOR CARE, CUSTODY AND MEDICAL TREATMENT DECISIONS**

I am (INSERT NAME OF PERSON WITH DISABILITY) and I live at (INSERT ADDRESS) , Michigan. I want (my mother), (INSERT NAME) and (my father), (INSERT NAME) to help me if I am sick and if I need to go to the doctor.

(My mother) and (my father) read this paper to me before I signed the paper. I understand what they told me about this paper before I signed the paper.

If I am sick, (my mother) or (my father) should take me to the doctor. If they are not at my house when I become sick, please call them to come to the doctor's office. If (my mother) or (my father) come to the doctor's office, I would like the doctor to talk to them and to tell them what is the matter.

I would like the doctor to ask either (my mother) or (my father) what the doctor should do. I would like the doctor to do what (my mother) or (my father) tells the doctor to do; they know what is best for me.

Sometimes a doctor says that I need to have a shot or some other care. Sometimes a doctor says that I need to take pills or medicine. I would like (my mother) or (my father) to decide if I should have a shot, or take a pill or other medicine. (My mother) or (my father) will also decide what other care I should have, but they will talk to me about what care I need.

I would also like (my mother) or (my father) to decide if I need to go to a dentist.

If I am very sick, I might need to go to a hospital. (My mother) or (my father) can decide if I need to go to the hospital. I would like all of the people at the hospital to speak with (my mother) or (my father) about what the people at the hospital should do for me. I would like (my mother) or (my father) to decide about my care at the hospital even if I am unable to understand what the doctor says about me. This is very important since I want the people at the hospital to try very hard to care for me if I am sick. If I need to have an operation because I am very sick, I would like to have the people at the hospital talk to (my mother) and (my father). (My mother) or (my father) will say "yes" or "no" and that is what the people at the hospital will do.

I understand that I want (my mother) or (my father) to help decide what care I need and I want people to listen to them about my care. If (my mother) or (my father) is not happy with my doctor, then they are able to get another doctor to take care of me.

(NAME OF PERSON WITH DISABILITY)

(DATE)

This is a draft to be used in creating a medical power of attorney. The language needs to be crafted to each person's level of comprehension. I think that if he or she understands what the document is intended to accomplish and what the document says, his or her signature should create an effective medical power. I have attempted to cover most of the issues that a standard medical power covers with the exception of the power to withdraw life sustaining or resuscitative treatment that would be covered in the standard Patient Advocate Designation accompanied by a Living Will.

**CONSENT TO AUTHORIZE ADVOCACY AND
RELEASE OF INFORMATION**

I, _____, hereby authorize Community Mental Health to release/exchange information with my friend/advocate, _____, which pertains to my services, programs and living situation. I also wish that my friend/advocate be invited to any and all meetings about me, and I do not want any decisions made without his/her input. If CMH has any documents I need to sign, my friend/advocate should receive copies and have time to go over them with me before I am asked to sign. This authorization, unless otherwise revoked by me, is intended to remain in effect for the duration of time I receive mental health services, etc. or until I revoke this authorization, whichever comes first.

(name)

(date)