





**Directive with Regard to Revocation** [changing my mind] *(initial only one of the boxes below)*

My wish is that, in accordance with state law, this mental health advance directive may be revoked by me at any time.

My wish is that I may revoke (change my mind about) this mental health advance directive **only** at times that I have the capacity to make my own mental health care decisions. I understand that I am choosing to give up the right to revoke my mental health advance directive whenever I do not have decision-making capacity and that I will regain that right whenever I recover decision-making capacity.

**Crisis Response** (completion optional)

The following signs and symptoms may indicate that I am in a mental health crisis:

---

---

---

---

---

---

---

I request the following interventions/activities in a mental health crisis regardless of setting (community, outpatient or inpatient) which may reduce my symptoms, make me more comfortable, and keep me safe:

---

---

---

---

---

---

---

---

In a psychiatric emergency, PLEASE AVOID the following interventions that make me feel worse:

---

---

---

---

---

---

---

---

Are you in recovery for, or do you have a substance use disorder (addiction)? \_\_\_\_\_

If yes, which substances are you most likely to use when your substance disorder is active?

---

---

---

---

---

**Temporary Custody of Dependents** (only applies when I lack the capacity to make my own mental health care decisions and choose to say whom I would want to watch my dependents)

I have the following dependent(s), which may include children, support service animal, pets, etc.:

---

---

---

---

In the event that I am unable to care for my dependent(s), I direct that the following person have temporary custody of my dependent(s) (only applies when I lack capacity):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

---

Phone Numbers: \_\_\_\_\_

Dependent(s): \_\_\_\_\_

For the following reason(s): \_\_\_\_\_

---

---

---

---

---

---

---

---

Name: \_\_\_\_\_

Address: \_\_\_\_\_

---

Phone Numbers: \_\_\_\_\_

Dependent(s): \_\_\_\_\_

For the following reason(s): \_\_\_\_\_

---

---

---

---

---

---

---

---

---

---

**Person/s to be notified at the time of discharge from a mental health care facility**  
(completion optional)

Name/s: \_\_\_\_\_

Address/es: \_\_\_\_\_

\_\_\_\_\_

Phone Numbers: \_\_\_\_\_

The Person I Want to Make Mental Health Care Decisions for Me  
When I Can't Make Them for Myself

I, \_\_\_\_\_, hereby  
*(Insert your name and address)*

appoint as my representative to act on my behalf to give, withhold or withdraw informed consent to mental health care decisions in the event that I am not able to do so myself.

**The person I choose as my mental health care representative is:**

\_\_\_\_\_  
*(Insert the name, address, area code and telephone numbers of the person you wish to designate as your representative)*

**The person I choose as my successor (backup) mental health care representative is:**

If my representative is unable, unwilling or disqualified to serve, then I appoint

---

*(Insert the name, address, area code and telephone numbers of the person you wish to designate as your successor representative)*

I do not wish to appoint a mental health care representative. *(Initial box for this preference)*

This appointment shall be for the purpose of mental health care decisions. Mental health care means treatment of “mental illness” as defined at West Virginia Code §27-1-2 with psychoactive medication, admission to and retention in a mental health care facility, electroconvulsive treatment and outpatient services. The representative appointed by this document is specifically authorized to be granted access to my medical records and other health information and to act on my behalf to consent to, refuse or withdraw any and all mental health care if my representative determines that I, if able to do so, would consent to, refuse or withdraw such treatment. The authority of the mental health care representative ceases when I have regained capacity to make mental health care decisions.

I appoint this representative because I believe this person understands my wishes and values and will make the mental health care decisions that I would make if I were able to do so, and because I also believe that this person will act in my best interest when my wishes are unknown. It is my intent that my family, my physician and all legal authorities be bound by the decisions that are made by the representative appointed by this document, and it is my intent that these decisions should not be the subject of review by any health care provider or administrative or judicial agency.

It is my intent that this document be legally binding and effective and that this document be taken as a formal statement of my desire concerning the method by which any mental health care decision should be made on my behalf during any period when I am unable to make such decisions.

In exercising the authority under this mental health advance directive, my representative shall act consistently with my special directives as stated in this advance directive.

THIS MENTAL HEALTH ADVANCE DIRECTIVE SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD OR WITHDRAW INFORMED CONSENT TO MY OWN MENTAL HEALTH CARE. INCAPACITY IS TO BE DETERMINED BY A QUALIFIED PHYSICIAN AND A SECOND QUALIFIED PHYSICIAN OR QUALIFIED PSYCHOLOGIST.

\_\_\_\_\_  
Signature of Principal

\_\_\_\_\_  
Date

I did not sign the principal's signature above. I am at least eighteen years of age and am not related to the principal by blood or marriage. I am not entitled to any portion of the estate of the principal or to the best of my knowledge under any will of the principal or codicil thereto, or legally responsible for the costs of the principal's medical or other care. I am not the principal's attending physician, nor am I the representative or successor representative of the principal.

Witness: \_\_\_\_\_ DATE: \_\_\_\_\_

Witness: \_\_\_\_\_ DATE: \_\_\_\_\_

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

I, \_\_\_\_\_, a Notary Public of said County, do certify that \_\_\_\_\_

\_\_\_\_\_, as principal, and \_\_\_\_\_, as witnesses,

whose names are signed to the writing above bearing date on the \_\_\_\_\_ day of

\_\_\_\_\_, 20 \_\_\_\_\_, have this day acknowledged the same before me.

Given under my hand this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Notary Public