DECLARATION FOR MENTAL HEALTH TREATMENT

(AS 47.30.970 Form of declaration)

I, James B. Gottstein being an adult of sound mind, wilfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by a court, two physicians that include a psychiatrist, or one physician and a professional mental health clinician, that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means electroconvulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a health care facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:
_____sleep deprivation_____

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:
_____ ~~I consent to the administration of the following medications:~~ _____
___XXX___ I do not consent to the administration of any psychotropic medications.

Conditions or limitations: Under no circumstances am I to be given any psychotropic medications against my will.

ELECTROCONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:
_____ I consent to the administration of electroconvulsive treatment.
__XXX__ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations: Under no circumstances am I to be given electroshock (ECV)..

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a health care facility for mental health treatment are as follows:

_____ I consent to being admitted to a health care facility for mental health treatment for up to _____ days.

____XX__ I do not consent to being admitted to a health care facility for mental health treatment.

This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

Conditions or limitations: _____No conditions or limitations_____

ADDITIONAL PREFERENCES OR INSTRUCTIONS

Every time I have experienced psychiatric symptoms it has been due to sleep deprivation and getting sleep has always allowed my psychiatric symptoms to subside. Therefore, without in any way diminishing the prohibition against any forced psychiatry or "treatment" contained above, if I run into trouble, people should work on helping me sleep.

Conditions or limitations: _____No Conditions or limitations_____

ATTORNEY-IN-FACT

I appoint:

NAME _____Don Roberts_____
ADDRESS _____264 Lilly Drive Apt. C-2, Kodiak, AK 99615_____
TELEPHONE NO. _____(907) 486-7629_____

to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following person to act as my attorney-in-fact:

NAME _____Christopher Cyphers___
ADDRESS _____420 L Street, Ste. 400, Anchorage, Alaska 99501-1937_____
TELEPHONE NO. _(907) 276-1969_____

My attorney-in-fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my attorney-in-fact. If my wishes are not expressed and are not otherwise known by my attorney-in-fact, my attorney-in-fact is to act in what my attorney-in-fact believes to be what I would choose if competent.

OTHER DOCUMENTS

_____ I have executed a general power-of-attorney or a power-of-attorney under AS 13.26 that includes the power to make decisions regarding health care services for myself. I authorize the attorney-in-fact appointed under this declaration and the attorney-in-fact appointed under a general power-of-attorney under AS 13.26 to serve

_____ jointly with consent of each other as to my mental health treatment;
_____ separately without each other's consent as to my mental health treatment.
___XXX__ I have not executed a general power-of-attorney or a power-of-attorney under AS 13.26 that includes the power to make decisions regarding health care services for myself.

_____

(Signature of Declarant/Date)

Address: 406 G Street, Suite 206, Anchorage, AK 99501
Telephone Number: (907) 274-7686

AFFIRMATION OF WITNESSES (Two Witnesses Required)

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, and that neither of us is a person appointed as an attorney-in-fact by this document; the principal's attending physician or mental health service provider or a relative of the physician or provider; the owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or a person related to the principal by blood, marriage, or adoption.

Witnessed By:

First Witness

Signature of Witness/Date: _____
Printed Name of Witness:_____
Address:_____
Telephone Number: _____

Second Witness

Signature of Witness/Date: _____
Printed Name of Witness:_____
Address:_____
Telephone Number: _____

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act in a manner consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a court, two physicians that include a psychiatrist, or one physician and a professional mental health clinician. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

(**Signature of Attorney-in-fact/Date**) _____

NAME _____Don Roberts_____
ADDRESS _____264 Lilly Drive Apt. C-2, Kodiak, AK 99615_____
TELEPHONE NO. _(907) 486-7629_____

(**Signature of Alternate Attorney-in-fact/Date**)_____

NAME _____Christopher Cyphers_____
ADDRESS _____420 L Street, Ste. 400, Anchorage, Alaska 99501-1937_____
TELEPHONE NO. _(907) 276-1969_____

NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

(1) This document allows you to make decisions in advance about three types of mental health treatment: psychotropic medication, electroconvulsive therapy, and short-term (up to 17 days) admission to a treatment facility. The instructions that you include in this declaration will be followed only if a court, two physicians that include a psychiatrist, or a physician and a professional mental health clinician believe that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

(2) You may also appoint a person as your attorney-in-fact to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the attorney-in-fact, to act in a manner consistent with what the person in good faith believes to be in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your attorney-in-fact at any time.

(3) This document will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

(4) You have the right to revoke this document in whole or in part at any time you have not been determined to be incapable. YOU MAY NOT REVOKE THIS DECLARATION WHEN YOU ARE CONSIDERED INCAPABLE BY A COURT, TWO PHYSICIANS THAT INCLUDE A PSYCHIATRIST, OR A PHYSICIAN AND A PROFESSIONAL MENTAL HEALTH CLINICIAN. A revocation is effective when it is communicated to your attending physician or other provider.

(5) If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.