Designation of Patient Advocate(s)

This form meets the legal requirements of the State of Michigan.

These instructions express my preferences about my medical care and/or mental health care if I am no longer able to make my own decisions as determined in writing by a treating physician and at least one other physician or licensed psychologist. (Michigan Compiled Laws "MCL" 700.5508). I want my family, caregivers, physicians, mental health professionals, and anyone else concerned with my health care needs to act in accordance with my wishes as stated in my Patient Advocate Designation Document and my Advance Directive.

By this instrument I intend to: (1) create a Durable Power of Attorney for Health Care under MCL Sections 700.5506-700-5512 of the Estates and Protected Individuals Code; (2) authorize my agent (patient advocate), at all times, to be able to request a copy of my medical records and obtain individually identifiable health information; and (3) authorize my agent to act as personal representative under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I, _____ appoint and designate the following person(s)
(print your name)
as my Patient Advocate.

Patient Advocate for Health Care:

Name_____

Address_____

Daytime phone #:_____ Cell phone #:_____

Patient Advocate for Mental Health Care (if different than Patient Advocate for Health Care):

Name_____

Address_____

Daytime phone #:_____ Cell phone #:_____

Successor Patient Advocate(s)

I appoint the following person(s), in the order listed, as my Successor Patient Advocate(s), if my Patient Advocate no longer accepts my appointment, is incapacitated, resigns, is removed, or is unavailable. My Successor Patient Advocate is to have the same powers and rights as my Patient Advocate.

First Successor Patient Advocate

Person to serve as (CHECK ONE):

☐ Designated Advocate for Health Care

☐ Designated Advocate for Mental Health Care

☐ Designated Advocate for Health Care AND Mental Health Care

Name_____

Address_____

Daytime phone #:_____ Cell phone #:_____

Second Successor Patient Advocate

Person to serve as (CHECK ONE):

☐ Designated Advocate for Health Care

☐ Designated Advocate for Mental Health Care

☐ Designated Advocate for Health Care AND Mental Health Care

Name_____

Address_____

Daytime phone #:_____ Cell phone #:_____

My Patient Advocate or Successor Patient Advocate(s) may only act if I am unable to participate in making decisions regarding my medical or mental health treatment.

My Patient Advocate or Successor Patient Advocate(s) may delegate his/her responsibilities to the next successor Patient Advocate if he or she is unable to act, but cannot delegate his/her responsibilities to someone I have not designated.