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Specific and Conditional Power of Attorney for Personal Care

This Power of Attorney for personal care is given by (subscriber's name) and (subscriber's) email address.

Appointment

I appoint **MHP RISK REDUCTION INC.** to be my attorney for my restricted care pursuant to applicable legislation in the event I am admitted to a mental care facility and I or other duly qualified members of my family or Court Appointees request or require an assessment of the care I am provided in such a facility.

Specific Instructions

Consent – Restrictions – Privacy

I appoint **MHP RISK REDUCTION INC.** to use such means and mechanisms as is reasonable to ensure that I am being properly treated in any mental health care facility according to the applicable standard of care for quality assurance purposes.

I authorize my Attorney to disclose any and all personal information **MHP RISK REDUCTION INC.** deem appropriate to reasonably protect my status as a patient receiving proper quality assurance care if in the opinion of my attorney I am not receiving reasonable and proper quality assurance care.

Assessors

If my capacity for personal care is in issue and an assessment of this capacity is to be performed, I name the following preferred assessor(s) or classes of assessor(s) to perform such assessment.

MY FAMILY PHYSICIAN

Revocation

This Power of Attorney Is a Restricted Power of Attorney and in no way revokes any other Power of Attorney.

Dated this day of (month & year) in the presence of the two Witnesses identified below

(Subscriber's Name)

(Subscriber's e-mail address)

Witness 1
Email:

Witness 2
Email: