

**STATEMENT OF DESIRES REGARDING MENTAL HEALTH CARE
(SOUTH CAROLINA)**

Addendum to the Health Care Power of Attorney of _____

This addendum is effective for a period of three (3) years from the date signed, unless previously revoked or replaced. The expiration or revocation of this addendum shall not revoke my Health Care Power of Attorney.

I have received mental health treatment in the past after having been diagnosed with the following illness / condition:

My doctor or other mental health provider is:

Name: _____

Address: _____

City, State, Zip: _____

Office Phone: _____ Cell (if known): _____

In the event that I become unable to give or refuse to give informed consent for mental health treatment, I wish to make clear my wishes regarding mental health treatment and case as stated below.

Admission to a treatment facility

My wishes regarding admission to a hospital or other facility for mental health treatment are as follows:
[choose only one of the following]

_____ **AUTHORITY GRANTED TO AGENT:** The person named as my health care Agent in my Health Care Power of Attorney shall have the authority to make decisions regarding my admission to a hospital or other facility for mental health treatment.

OR

_____ **CONSENT:** I consent to being admitted to a hospital or other facility for mental health treatment.

OR

_____ **NO CONSENT:** I DO NOT consent to being admitted to a hospital or other facility for mental health treatment.

OR

_____ **LIMITED CONSENT:** I consent to being admitted to a hospital or other facility for mental health treatment, except for the following: *[list any institutions which you do not want to be admitted to]*