Sample Supported Decision-Making Agreement (open-ended)

This is an example of a Supported Decision-Making Agreement. It can be modified or customized for individual needs
A person may use Supported Decision-Making without any document.*

Supported Decision-Making Agreement

MO Rev Stat § 475.075 (13) (4)

This document IS _____ / IS NOT _____ legally binding. ***Only a person with the legal right and capacity to contract can make a legally binding agreement.***

I, _____, make this supported decision-making agreement to choose supporters to help me make decisions. I am choosing to make this agreement. I may end this agreement at any time. These supporters **DO NOT** make decisions for me. They give me information, advice, and other support so I can make decisions for myself.

My Name: _____

Created by the Missouri Consortium for Supported Decision-Making, with assistance from:
Missouri Protection & Advocacy Services
A Public Interest Law Firm Since 1977

1. **Health Care**

I DO _____ / DO NOT _____ want help with health care. Here is a list of people I want to help me with health care decisions:

Name	Relationship	Home Address	Email	Phone number

I allow these supporters to help me make decisions about my physical and mental health. These people do not make decisions for me - they help me make decisions myself.

These supporters can help me in these ways:

These supporters MAY NOT do these things:

2. Financial Decision-Making

I DO _____ / DO NOT _____ want help with financial decisions. Here is a list of people I want to help me with financial decisions:

Name	Relationship	Home Address	Email	Phone number

I allow these supporters to help me make decisions about my finances. These people do not make decisions for me - they help me make decisions myself.

These supporters can help me in these ways:

These supporters MAY NOT do these things:

3. Where I Live and Community Living

I DO _____ / DO NOT _____ want help with decisions about where I live and community living. Here is a list of people I want to help me with these decisions:

Name	Relationship	Home Address	Email	Phone number

I allow these supporters to help me make decisions about where I live and community living. These people do not make decisions for me - they help me make decisions myself.

These supporters can help me in these ways:

These supporters MAY NOT do these things:

4. **Education**

I DO _____ / DO NOT _____ want help with decisions about education. Here is a list of people I want to help me with decisions about education:

Name	Relationship	Home Address	Email	Phone number

I allow these supporters to help me make decisions about my education. These people do not make decisions for me - they help me make decisions myself.

These supporters can help me in these ways:

These supporters MAY NOT do these things:

5. Employment

I DO _____ / DO NOT _____ want help with decisions about employment.
Here is a list of people I want to help me with employment decisions:

Name	Relationship	Home Address	Email	Phone number

I allow these supporters to help me make decisions about my employment. These people do not make decisions for me - they help me make decisions myself.

These supporters can help me in these ways:

These supporters MAY NOT do these things:

6. **Other**

I DO _____ / DO NOT _____ want help with other decisions. Here is a list of people I want to help me with making these decisions:

Name	Relationship	Home Address	Email	Phone number

I allow these supporters to help me make certain decisions. These people do not make decisions for me - they help me make decisions myself.

These supporters can help me in these ways:

These supporters MAY NOT do these things:

This agreement starts when I sign it, and ends when I choose to end it. Any supporter may leave the agreement by telling me in writing. If a supporter leaves the agreement, the rest of the agreement continues.

Signed this date: _____

_____ _____

Signature of Person Entering This Agreement | Printed Name of Person Entering This Agreement

I agree to be a Supporter under this agreement:

_____ _____

Signature of Supporter 1 | Printed Name of Supporter

I agree to be a Supporter under this agreement:

_____ _____

Signature of Supporter 2 | Printed Name of Supporter

I agree to be a Supporter under this agreement:

_____ _____

Signature of Supporter 3 | Printed Name of Supporter

I agree to be a Supporter under this agreement:

_____ _____

Signature of Supporter 4 | Printed Name of Supporter

I agree to be a Supporter under this agreement:

_____ _____

Signature of Supporter 5 | Printed Name of Supporter

Authorization Under HIPAA to Disclose Protected Health Information

TO WHOM IT MAY CONCERN:

This Authorization is made pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and its regulations, including 45 C.F.R. § 164.508.

I, _____, hereby authorize all "covered entities" as defined in HIPAA, including but not limited to any hospitals or other health service operations, doctors (whether medical, osteopathic, podiatric or chiropractic), psychiatrists, psychologists, therapists, nurses, clinics, pharmacies, laboratories, assisted living facilities, residential care facilities, nursing homes medical insurance company or any other health care provider or affiliate), to freely release all of my medical records to any or all of the following named persons (my "Agents"):

_____	_____
Printed Name of Supporter	Address
_____	_____
Printed Name of Supporter	Address
_____	_____
Printed Name of Supporter	Address
_____	_____
Printed Name of Supporter	Address
_____	_____
Printed Name of Supporter	Address

My Agent may, at my Agent's discretion, direct that any of my medical records be released directly to a third party, including any licensed physician.

The purpose of this Authorization is to allow my Agents to obtain any and all medical records in order to assist me in supported decision-making concerning my health care.

I understand this authorization may be revoked in writing at any time except to the extent already acted upon. To revoke this authorization I must send a revocation in writing to:

_____**, attorney at law**, at address _____.

This authorization will expire six months after my death.

I understand that my medical records disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the privacy regulations.

A photocopy of this authorization shall be considered as effective and valid as the original.

Signed this _____ (day) of _____ (month), _____ (year).

_____ _____

Signature Printed Name

Authorization Under FERPA to Disclose Educational Records

To the following institution and records provider:

_____

This Authorization is made pursuant to the Family Educational Rights and Privacy Act (FERPA) and its regulations.

Please provide information from the educational records of the following person:

_____

Student

Please provide the information to the following person or people:

_____

Person(s) and Relationship to Student

_____

Person(s) and Relationship to Student

I authorize release of all records. This information is released for the purpose of getting support with my decisions, as specified in my Supported Decision-Making Agreement.

I understand that I may end this authorization in writing at any time except to the extent already acted upon. I may end this authorization by giving written notice to the institution/records provider listed above.

I understand that my records disclosed because of this authorization may be disclosed again by the recipient and may no longer be protected by the privacy regulations.

A copy of this authorization is as effective and valid as the original.

Signed this date: _____

_____ _____

Signature Printed Name