I submit the information herein to confirm my identity if a health care provider requests a copy of my advance directive.

I declare that the Registrant who signed this document is personally known to me, that he/she signed or acknowledged this document in my presence, and that he/she appears to be of sound mind and under no duress or undue influence.

Registration is free of charge. Registry shall not be liable for the improper transmission/disclosure of my advance directive.

I authorize the Registry to send a copy of my advance directive to any health care provider that requests a copy of it, provided the request conforms to the Registry’s policies and procedures. The Registry is not authorized to share my personal information with parties other than health care providers (as defined herein). A copy of this Agreement may be used in place of the original document.

I. Registration and Certification: I submit the information herein to confirm my identity if a health care provider requests a copy of my advance directive. I certify that this information is correct, and that the attached advance directive is my currently effective advance directive, which was properly executed in accordance with the laws of the state where it was executed. If the attached advance directive is a copy, I certify that it is a true and correct copy of the original document. I agree to immediately notify the Registry, in writing, at the Registry’s address listed above, in the event of my revocation of this Registration, or any changes to the information provided. I understand that I can only register through a Registry member Health Care Provider or a Registry Community Partner. The Registry’s member Health Care Providers and Community Partners are not owned or operated by the Registry, and they cannot change any terms of this Registration Agreement; any oral changes are not effective.

II. Authorization: I authorize the Registry to send a copy of my advance directive to any health care provider that requests a copy of it, provided the request conforms to the Registry’s policies and procedures. The Registry is not authorized to share my personal information with parties other than health care providers (as defined herein). A copy of this Agreement may be used in place of the original document.

III. Limitations on Liability: Registration is free of charge. Registry shall not be liable for the improper transmission/disclosure of my advance directive.

IV. Term: This Agreement shall remain in effect until Registry receives reliable information that the Registrant is deceased, the Registrant requests, in writing, that the Agreement be terminated, or if registration is cancelled pursuant to the Registry’s policies and procedures. When the Agreement is terminated, Registry will use best efforts to remove Registrant’s advance directive from its files.

I hereby agree to the above terms and certify to the accuracy of the information provided. I am legally capable of executing this registration.

X__________________________________________ DATED: _______/_______/_______

Signature of Registrant or Legal Guardian (Guardian must provide proof of authority)

WITNESS STATEMENT: I declare that the Registrant who signed this document is personally known to me, that he/she signed or acknowledged this document in my presence, and that he/she appears to be of sound mind and under no duress or undue influence.

Signature: ___________________________________________ DATED: _______/_______/_______

(Witness #1)

Signature: ___________________________________________ DATED: _______/_______/_______

(Witness #2)

Print Name: ___________________________________________ DATED: _______/_______/_______

Print Name: ___________________________________________ DATED: _______/_______/_______