U.S. Advance Care Plan Registry® Registration Agreement

Registrant's Identifying Information (Please print clearly) **SOURCE CODE:** 36901001

Name: First_____ Middle_____ Last_____ Suffix_____

Date of birth: Month_____Day_____Year_____(4 digits)

Street Address:_____Apt #_____

City:_____ State:_____ Zip Code:_____

Primary Phone #: (_____) _____-_____ Alternate Phone #: (_____) _____-_____

Email Address:_____(If registrant does not have an email address, please insert the email address of the emergency contact person instead)

Annual update reminders will be sent via email – email addresses will never be shared or sold

Emergency Contact Name:_____

Phone #: (_____) _____-_____

I,_____("Registrant" or "I"), authorize U.S. Advance Care Plan Registry®, with a mailing address of P.O. Box 2789 Westfield, NJ 07091-2789 ("Registry"), to electronically store a copy of my advance car e planning document(s) provided to Registry with this registration form or submitted subsequently, including but not limited to an advance directive, living will, health care proxy, durable power of attorney for health care and/or financial matters, Medical or Physician Orders for Life-Sustaining Treatment (MOLST or POLST), Do Not Resuscitate (DNR) order, organ donation wishes and emergency contact information (hereinafter "document(s)"). I further authorize the Registry to make available a copy of the stored document(s) to any health care provider or other person believed charged with giving effect to my document(s) or assisting in same, who requests it in conjunction with my care, provided such a request is consistent with the Registry's policies and procedures, or as deemed advisable by the Registry in an emergency situation, or as required by law. The document(s) that I am providing is my current, effective document(s), and was signed and witnessed in accordance with the law of the state of my residence.

I hereby authorize Registry to make available a copy of my document(s) to hospitals, physicians, or other health care providers involved with my care, or to anyone who has access to the wallet identification card provided to me by Registry. I understand this authorization is voluntary. I agree to notify Registry immediately if I decide to revoke or change my document(s) that is stored with Registry, and to provide Registry with a copy of any additional document(s) that I sign. I understand that unless I terminate this authorization or inform Registry of revocation or changes to my document(s), the document(s) stored with Registry will be provided to health care providers in accord with Registry's policies and practices.

I understand that Registry makes no representations about the validity of my document(s) under federal or state law and that Registry bears no responsibility for the actions taken by health care providers in relation to my document(s). I hereby waive any and all legal claims against Registry for the actions and omissions by any health care providers who receive a copy of my document(s) from Registry and for any damages arising from the transmission or disclosure of the document(s) I provide to Registry. Registry shall not be liable for the loss, destruction or unavailability of all or part of my document(s).

I understand that I may revoke this authorization at any time by giving written notice of my revocation to Registry. This Agreement will remain in force until revoked by me or until terminated in accordance with the agreement between me and Registry or until registration is cancelled pursuant to the Registry's policies and procedures. When the Agreement is terminated, I understand that Registry will remove my document(s) from its files.

I understand that anyone who gains access to my wallet ID card provided by Registry can use it to gain access to my document(s) and personal information stored with Registry, and I will not hold the Registry liable for such authorized or unauthorized access.

I hereby agree to the terms set forth herein.

X_____ Dated_____/_____/_____

Signature of Registrant