



AssuringYourWishes.org

LIVING WILLS • HEALTH CARE PROXIES • OTHER DIRECTIVES

**ASSURINGYOURWISHES.ORG ADVANCE DIRECTIVE AUTHORIZATION FORM**

By signing this form, I am requesting that AssuringYourWishes.org make available my most recent advance directive, a copy of which accompanies this Advance Directive Authorization Form, to my health care proxy or alternate healthcare proxy, legal guardian (if applicable) and all health care providers involved in my medical care. I understand that I may change or revoke the advance directive accompanying this form at any time, and that I may also revoke my authorization for AssuringYourWishes.org to post my advance directive at any time. I agree to notify AssuringYourWishes.org of any such change or revocation in writing. If I revoke my advance directive or I revoke my authorization for AssuringYourWishes.org to post my advance directive, my advance directive will be removed from the AssuringYourWishes.org website. If I change my advance directive, I agree to submit a new Advance Directive Authorization Form and a copy of my new advance directive to AssuringYourWishes.org. The new advance directive will then be posted on the AssuringYourWishes.org website, and the old advance directive will be removed. I agree that AssuringYourWishes.org will not be held responsible for the release of my advance directive information in accordance with the terms agreed to, prior to AssuringYourWishes.org's receipt of written notification of a change to my advance directive, or a revocation of my advance directive or revocation of my authorization for AssuringYourWishes.org to post my advance directive.

I understand that I will receive three (3) AssuringYourWishes.org identification cards with my name and password listed. I understand that my health care proxy or alternate healthcare proxy, legal guardian (if applicable) and all health care providers involved in my medical care will be granted access to my advance directive when medically necessary, and only those individuals to whom I have given my password will be able to access my advance directive. I understand that additional information regarding the Advance Directive Deposit program, including the privacy and security policy of AssuringYourWishes.org is available on the AssuringYourWishes.org website.

While AssuringYourWishes.org attempts to provide reliable posting services for your Advance Directive, occasionally circumstances beyond our control interfere with the internet connectivity or server stability where the Advance Directives are posted. Therefore, you acknowledge and agree that the posting of the Advance Directive as a free Service, is provided AS IS and AS AVAILABLE, without warranty of any kind.

AssuringYourWishes.org EXPRESSLY DISCLAIMS ANY AND ALL WARRANTIES OF ANY KIND, WHETHER EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO: (A) ANY WARRANTIES AS TO THE AVAILABILITY, ACCURACY, COMPLETENESS, CURRENTNESS, VALIDITY, EFFECTIVENESS OR RELIABILITY OF THE POSTED ADVANCE DIRECTIVE AVAILABLE THROUGH THE SERVICE, OR THE SERVICE ITSELF; (B) ANY WARRANTIES THAT THE SERVICE WILL BE UNINTERRUPTED, TIMELY, SECURE, OR ERROR FREE, OR THAT SOFTWARE DEFECTS WILL BE CORRECTED; AND (C) FITNESS FOR A PARTICULAR PURPOSE. NO ADVICE OR INFORMATION, WHETHER ORAL OR WRITTEN, OBTAINED BY YOU FROM AssuringYourWishes.org OR THROUGH THE SERVICE SHALL CREATE ANY WARRANTY NOT EXPRESSLY MADE HEREIN.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ E-mail \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Note: If the individual signing this form is not the same as the person whose name is listed on the advance directive, print the name of the individual signing the form, and indicate whether the individual is the named person's health care proxy, alternate health care proxy or legally appointed guardian. Please also provide proof of the authorization to act on behalf of the named person.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Authority to Act on Behalf of the Named Person

Please mail to: Assuring Your Wishes.Org C/O United Hospice of Rockland, Inc., 11 Stokum Lane  
New City, NY 10956