

AssuringYourWishes.org\United Memorial Medical Center
Advance Directive Registry Authorization Form

Name _____ Date of Birth _____

Mailing Address _____

City _____ State _____ ZIP _____

Phone Number _____ E-Mail _____

Authorization to Include My Advance Directive in the Advance Directive Registry

Assuring YourWishes.org and United Memorial Medical Center are giving me the opportunity to file my advance directive with the Assuring Your Wishes registry so that it will be available to individuals to whom I have given my pass code and all health care providers who are involved in my medical care. By signing this Authorization Form, I am requesting that AssuringYourWishes.org make available my most recent advance directive, a copy of which is attached, to individuals to whom I have given my pass code and all health care providers involved in my medical care.

I understand that I will receive three (3) AssuringYourWishes.org identification cards with my name and pass code listed. I understand that all health care providers involved in my medical care will be granted access to my advance directive. In addition to these providers, only those individuals to whom I have given my pass code will be able to access my advance directive. I understand that additional information regarding the AssuringYourWishes.org's web-based registry for advance directives, including the privacy and security policy of AssuringYourWishes.org, is available at www.sharingyourwishes.org.

Revoking or Changing My Advance Directive or Revoking This Authorization

I understand that I may change or revoke the advance directive attached to 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 the United Memorial Medical Center of any such change or revocation in a writing mailed to the United Memorial Medical Center. If I revoke my advance directive or I revoke my authorization for my advance directive to be posted, 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 Registry Authorization Form and a copy of my new advance directive to the United Memorial Medical Center. The new advance directive will then be posted on the AssuringYourWishes.org website, and the old advance directive will be removed. I agree that the United Memorial Medical Center and AssuringYourWishes.org will not be held responsible for the release of my advance directive information in accordance with the terms agreed to, prior to the United Memorial Medical Center'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 my advance directive to be posted on the registry.

Limitation of Liability and Warranty Disclaimer

While AssuringYourWishes.org attempts to provide reliable posting services for my advance directive, occasionally circumstances beyond its control interfere with the internet connection or the stability of the computer server where the advance directives on the registry are posted. Therefore, I acknowledge and agree that the posting of my advance directive on the registry as a free service to me, is provided as is and as available, without warranty of any kind.

AssuringYourWishes.org and the United Memorial Medical Center expressly disclaim any and all express or implied warranties of any kind, 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 registry, or the registry itself; (b) any warranties that the registry 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 me from AssuringYourWishes.org or through the registry shall create any warranty with the exception of any warranty contained in the Your Privacy & Security at *AssuringYourWishes.org*. statement.

Please call the Long Term Care Task Force at (585-343-1611) with any questions about the Assuring Your Wishes Registry or this Authorization Form.

I have read and understand this form, I have been given the opportunity to ask questions, and all of my questions have been answered.

Signature _____ Date _____

Note: If the person who signed the advance directive is unable to sign this Authorization Form, please print the name of the individual signing this Authorization Form in the space provided below, and indicate source of authority to sign this Authorization Form and provide proof of such authority.

_____ Authority: _____
Print Name

Please mail the Authorization Form to: AssuringYourWishes.org C/O United Memorial Medical Center, Attn: Quality Management, 127 North Street, Batavia, NY 14020