

**AssuringYourWishes.org\Cayuga Medical Center at Ithaca**  
**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 Cayuga Medical Center at Ithaca 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](http://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 Cayuga Medical Center of any such change or revocation in a writing mailed to Cayuga 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 Cayuga 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 Cayuga 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 Cayuga 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 Cayuga 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 statement at *AssuringYourWishes.org*.

Please call Sharing Your Wishes c/o the Health Planning Council of the Human Services Coalition of Tompkins County (607)273-8686 with any questions about the Assuring Your Wishes Registry or this Authorization Form.

**Authorization to Have My Advance Directive on File at  
Cayuga Medical Center at Ithaca**

By signing this authorization, I agree to also have my Advance Directive on file at Cayuga Medical Center.

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.

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

Please mail the Authorization Form to: Sharing Your Wishes c/o Cayuga Medical Center at Ithaca, 101 Dates Drive, Ithaca, NY 14850.