IDAHO HEALTHCARE DIRECTIVE REGISTRY
Your voice. Your choice.

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Advance Directive Registration Form

This form **is required** to add a new Advance Directive or POST form to the registry. Email completed forms to IHDR@dhw.idaho.gov or mail to the address below. If you have questions about completing this form or related documents, please call (208) 334-5501 to speak with a registry representative.

I want to:

☐ Store a copy of my Advance Directive and/or POST form in the Registry.

☐ Replace my previously registered Advance Directive and/or POST form with the one provided.

☐ Revoke my Advance Directive and/or POST form from the Registry.

The personal information provided with this request is to store my Advance Directive and/or POST form in the Idaho Healthcare Directive Registry. I certify the document(s) that accompany this agreement is my effective healthcare directive executed in accordance with State of Idaho laws.

I understand that registry use is entirely voluntary and not required. Registration only makes these documents more accessible to healthcare professionals and the individuals that I choose.

REGISTRATION CONFIRMATION WILL BE SENT TO THE REQUESTOR VIA EMAIL ONLY
PAPER DOCUMENTS WILL NOT BE RETURNED

Fill in this registration form and email/enclose it with a COPY of your Advance Directive and/or POST form.

First Name, Middle Name, Last Name * required		Date of Birth * required
Address * required		Gender (M/F/other)*required
City, State, Zip Code * required	Phone * required	Last Four SSN *(optional)*
Email Address * required and cannot be used by another registrant. If no email, enter "none"		

*Fill in **ONLY IF** this registration form is being completed by someone other than the individual listed above.*

First Name, Last Name		
Address	City, State, Zip Code	
Phone	Email Address	

_____
Signature of Registrant

_____
Date

Idaho Healthcare Directive Registry
450 W State Street, 4th Floor
Boise, Idaho 83702-0036