Montana Department of Justice
Office of Consumer Protection

MONTANA
END-OF-LIFE REGISTRY
https://dojmt.gov/consumer/end-of-life-registry/

Consumer Registration Agreement

For office use only

PO Box 201410, Helena, MT 59620-1410 • Phone (406) 444-0660 or (866) 675-3314 • E-mail: endofliferegistry@mt.gov

This form indicates your desire to store an advance directive in the Montana End-of-Life Registry, to replace or remove an Advance Directive already in the Registry, or to request a replacement wallet card.

- Read this Agreement carefully and fill in Sections A through C completely.
- Attach your witnessed Advance Directive.
- Return this Agreement with your Advance Directive to the Office of Consumer Protection at the address above.
- Your Consumer Registration Agreement will be processed within three weeks. You will receive further information in the mail.

Section A

Prefix	First Name	Middle Name or Initial	Last Name	Suffix

Gender	Date of Birth (Month/Day/Year)	Mother's Maiden Name	Social Security Number	Phone Number

Mailing Address

City	State	Zip	County	Country

Section B

Pick a level of privacy:

- ☐ **Standard Privacy:** If the information on my wallet card is unavailable, in addition to health care providers, people who enter my Social Security Number, date of birth and mother's maiden name can view my advance directive.
- ☐ **Higher Privacy:** Only people who have the information from my wallet card and health care providers can view my advance directive.

I want to:

- ☐ **Store an advance directive in the Registry.**
- ☐ **Replace an advance directive in the Registry with a new one.**
- ☐ **Add an Addendum to my current directive**
- ☐ **Remove my advance directive from the Registry.**
- ☐ **Request a replacement wallet card.**

Section C

I am providing this personal information along with my advance directive, with the understanding that my personal information will be stored in a secure Department of Justice database and will not be available to the public. I certify that the advance directive that accompanies this Agreement is my current effective advance directive and was duly executed, witnessed and acknowledged in accordance with Section 50-9-103 of the Montana Code Annotated.

I understand that:

- my advance directive will be entered in the Montana End-of-Life Registry free of charge;
- this authorization is voluntary;
- this authorization to store my advance directive in the Montana End-of-Life Registry will remain in force until I revoke it;
- I may revoke this authorization at any time by giving written notice of my revocation to the address listed above; and

no agency, provider or individual may be held liable for any action based on this authorization before a written notice of revocation has been entered into the Registry.

_____ _____

Signature of Person Signing This Agreement Date

If the person named in the advance directive is unable to sign this form, and you have legal authority to sign for that person, please check the source of your authority and provide proof thereof. ☐ Durable Power of Attorney ☐ Court Appointed Guardian