



**Arizona Health Care Directives Registry**  
**ARIZONA SECRETARY OF STATE**

1700 W. Washington Street, 7th Floor, Phoenix, AZ 85007-2888  
(602) 542-6187  
(800) 458-5842 (within Arizona)  
Website: www.azsos.gov

FOR OFFICE USE ONLY - REV. 09/28/09

**REGISTRATION AGREEMENT**

**About this agreement:**

This agreement shall be used for the registration of a Health Care Directive in the State of Arizona under the authority of A.R.S. § 36-3291 - 3297

This form/agreement must be written legibly or computer generated. For your convenience, this form has been designed to be filled out and printed online at the website referenced above.

**Fees:** None

**Processing time-frame:** three weeks

**How to complete this form:**

- Read this agreement carefully, and fill in all blank spaces
- Attach a copy of your witnessed or notarized Health Care Directive to this Agreement
- DO NOT send your original Health Care Directive Form
- Sign and date this Agreement
- Return by mail to:  
Arizona Secretary of State Dept A  
1700 W. Washington Street, 7th Fl., Phoenix, AZ 85007  
Return in person: Tucson: 400 W. Congress, Ste. 252

Last Name		First Name		Middle Name
Address				
City	State		Zip	
Phone	Birth Date (month/day/year)		Last 4 digits of Social Security Number	
Printed name as you want it listed on your membership card				
<b>Address to return documents and wallet card (IF DIFFERENT FROM ADDRESS ABOVE)</b>				
Name				
Address				
City	State		Zip	
I want to: <input type="checkbox"/> Store a health care directive(s) in the Registry <input type="checkbox"/> Replace a health care directive(s) now in the Registry with a new one <input type="checkbox"/> Add an additional document to my currently stored directive(s) <input type="checkbox"/> Remove my health care directive(s) from the Registry <input type="checkbox"/> Request a replacement wallet card (no change to health care directive(s) in Registry) <input type="checkbox"/> Change Registration Agreement information (such as new a address)				

**You must complete and sign the Agreement on Page 2 of this form.**



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I am providing this personal information, along with a copy of my advance directive, with the understanding that this information will be stored in the Arizona Health Care Directive Registry. I certify that the advance directive that accompanies this Agreement is my currently effective advance directive, and was duly executed, witnessed and acknowledged in accordance with the laws of the State of Arizona.

I understand this authorization is voluntary. This authorization to store my advance directive in the Arizona Health Care Directives Registry will remain in force until revoked by me. I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will NOT affect any action you took in reliance on this authorization before you received my written notice of revocation.

**Contact Office:** Office of the Arizona Secretary of State Dept A  
**Telephone:** 602-542-6187    **E-mail:** [AD@azsos.gov](mailto:AD@azsos.gov)  
**Address:** 1700 W. Washington Street, 7th Floor, Phoenix, AZ, 85007

Your registration form will be processed within three (3) weeks. You will receive further information in the mail. In order to complete the registration of your health care directive(s) you are required to reply to the letter that you will receive.

For further assistance please contact the Arizona Secretary of State at (602) 542-6187 or visit us online at: [www.azsos.gov](http://www.azsos.gov)

Signature of person completing this agreement	Date
Printed Name	



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