

A no-cost service provided by the office of Nevada Secretary of State Barbara K. Cegavske

LivingWillLockbox.com  
Protecting Your Wishes



## Authorization to Change Form

PLEASE TYPE OR PRINT CLEARLY USING INK

ABOVE SPACE IS FOR OFFICE USE ONLY

This form must be used by the Registrant for documents stored in the LivingWillLockbox to authorize a change and for update to their advance directive documents on file.

### Registrant Information (please type or print clearly)

Date of Birth: (as currently filed)   
mm/dd/yyyy

Legal Name:

First / Middle / Last

**Corrected** Date of Birth:   
mm/dd/yyyy

Primary Mailing Address:

Address City State Zip Code

Phone Number:   Registrant ID #: (Found on Wallet Card)   
Area Code Number

### Changes to Registration Agreement (check each box that applies)

Changes **REQUIRING** additional documents:

- Add additional health care declaration document(s) to my currently stored documents.  
(Attach copy of additional document(s) to this form)
- Replace currently stored health care declaration document(s) with new one(s).  
(Attach copy of new document(s) to this form)

Changes **NOT REQUIRING** additional documents to accompany this form:

- Revoke/Delete: Remove my health care declarations document(s) from the Lockbox. I am aware that I will no longer be registered with the Living Will Lockbox.
- Change of **Registrant** Information: (if an address change, indicate which address set forth on the agreement is being changed) (Date of Birth may be changed in above registrant information area.)

Primary Mailing Address

Secondary Address

New Address:

Address City State Zip Code

Phone Number:    
Area Code Number

Alternate Number:    
Area Code Number

**Change of Emergency Contact Information:** (Please provide any new information below)

Primary Emergency Contact (Person listed on health care declaration documents, Legal Guardian or Family)

Name:  Relationship:

Address City State Zip Code

Phone Number:   Alternate Number:    
Area Code Number Area Code Number

Contact is authorized access to my Advance Directive in case of emergency:  Yes  No

Alternate Emergency Contact (Person listed on health care declaration documents, Legal Guardian or Family)

Name:  Relationship:

Phone Number:    
Area Code Number

Contact is authorized access to my Advance Directive in case of emergency:  Yes  No

*I certify that this form accurately represents the changes I have made. Additionally, I authorize the changes to be reflected in the Lockbox.*

**X** \_\_\_\_\_   
Signature of Registrant Date

**If Authorization to Change Form is prepared and submitted by someone other than the Registrant, the following must be completed:**

*I declare under penalty of perjury that pursuant to NRS 132.045, I am an agent of the above said Registrant and submitting this Authorization to Change Form on his/her behalf.*

Print Name of Person who Prepared this Document Entity/Organization Name

Contact Number:    
Area Code Number

**X** \_\_\_\_\_   
Signature of Person who Prepared this Document Date

To confirm changes have been made please go to [www.LivingWillLockbox.com](http://www.LivingWillLockbox.com) and click on Access to Documents to view your documents on file. Please allow up to 12 business days for the changes to be viewed online.

**Attach photocopies of all documents.**

**Please do not send originals as we cannot be responsible for their safe keeping.**



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