

## Registration

I hereby submit my mental health advance directive to the Division of Mental Health and Addiction Services in the New Jersey Department of Human Services to be registered.

I choose the following password that will permit access for me and anyone with whom I share it: \_\_\_\_\_ (If left blank, one will be assigned and provided to you.)

I further understand that a licensed health care provider who is providing me with mental health care may be able to access my directive if needed. No other person will be permitted to see the directive (except as required for administration of the registry) without my permission.

Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Date \_\_\_\_\_

Please provide the following contact information for confirmation:

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Email

Witness:

Signature \_\_\_\_\_ Print Name \_\_\_\_\_

Date \_\_\_\_\_

**Send the original of this registration form and a copy of your entire mental health care advance directive to:**

NJDMHS Registry  
PO Box 700  
222 South Warren St  
Trenton, NJ 08625

You may also submit other documents to be registered that affect your legal ability to consent, such as a health care advance directive, durable power of attorney, temporary or limited guardianship orders, etc., which the registry will accept in its discretion.