REVOCATION OF

_____

I, _____, of _____, hereby revoke my _____ dated _____. The power and authority granted to my physician or any health care provider is revoked and withdrawn and this document provides notice of such revocation.

Dated this _____ day of _____, at _____.

_____
_____

Witness Signature: _____

Witness Name: _____
Witness Address: _____
_____
_____

Witness Signature: _____

Witness Name: _____
Witness Address: _____
_____
_____

Names of institutions/individuals who have been provided a copy of this revocation:
_____

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