

**NOTICE OF  
ADVANCE DIRECTIVE REVOCATION**  
*(Complete only if you intend to revoke your advance directive)*

This document is to provide Notice of Revocation of an advance directive entitled:

\_\_\_\_\_ *(title of directive – i.e., living will, power of attorney for health care, etc)*

Created in the name of:

\_\_\_\_\_ *(name of individual completing the directive)*

With a date of execution as follows:

\_\_\_\_\_ *(enter date the document was signed by the principal or proxy)*

This Revocation is being validated by one of the following means:

- \_\_\_\_\_ The signature of the principal
- \_\_\_\_\_ A witnessed statement to a current medical care provider
- \_\_\_\_\_ A witnessed statement to another involved adult

**Signed:** \_\_\_\_\_  
*(By the Principal, OR as: “\_\_ (other’s signature) \_\_ for the Principal,” as indicated above)*

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

**Witnesses:** *Under penalty of perjury, I declare that the Principal (person) named in the advance directive cited herein did willfully, knowingly and voluntarily revoke this directive by affixing his or her signature (above) in my presence. If the above signature is not that of the Principal, I did personally witness him or her direct the signing of this Revocation willfully, knowingly, voluntarily and without reservation.*

Signed: \_\_\_\_\_  
Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Signed: \_\_\_\_\_  
Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Notice of this Revocation has been given to:

\_\_\_ Involved Physicians; \_\_\_ The Agent/Proxy; \_\_\_ The Alternates ; \_\_\_ Medical Records