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

_____

5348 Vegas Dr, #11 – Las Vegas, NV. 89108.
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