Notice of Health Care Agent/Proxy Resignation or Deferral

(*this form must completed by the agent/proxy resigning or deferring their role*)

Patient Name: _____ Medical Record #:_____

Date of Original Appointment: _____

Statement of Voluntary Resignation or Decision-Making Deferral:

"I am aware of my appointment as a health care agent/proxy to make medical treatment decisions for the Principal named above and in an associated advance directive document. However, I choose to relinquish this role to the next most eligible person(s), as named above. I do so for reasons of decision-making efficacy, and/or for personal, philosophical, religious, or other reasons. I relinquish this authority knowing that treatment decisions resulting in the prolonged life or precipitous death of the Principal named herein could result. I agree to support any good-faith decision(s) made by any alternate agent/proxy recorded within the advance directive document, or by other family members or appointed representative(s) if no other appointment exists.

"I understand that this Resignation becomes effective immediately. Should I later wish to resume my role, I understand that I may only do so by reappointment by the Principal, or by agreement by any alternate agent/proxy that has been named, or by consensus of others who have been functioning in this decision-making role.

"If I am resigning as agent or proxy during any time in which the Principal retains decisional capacity, I attest that I have already notified the Principal of my decision both verbally and in writing. If I am resigning following the Principal's loss of decision-making capacity, I attest that I have already notified the Principal's immediate care physician and any alternate agent(s) both verbally and in writing.

Signed: _____

Relationship: _____

Address: _____