

# Revocation of Durable Health Care Power of Attorney

I, \_\_\_\_\_ (printed name),  
of (address) \_\_\_\_\_  
do revoke the Durable Health Care Power of Attorney dated \_\_\_\_\_, 20\_\_\_\_\_,  
which was granted to \_\_\_\_\_ (printed name),  
of (address) \_\_\_\_\_, to  
act as my attorney-in-fact for health care decisions and I revoke any appointment of the above  
person as my health care agent, health care representative, or health care proxy.

Dated \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Signature of person revoking power of attorney

\_\_\_\_\_  
Printed name of person revoking power of attorney