



**MAINEGENERAL HEALTH
REVOCATION OF ADVANCE DIRECTIVE**

I, _____ (Patient's Name), wish to revoke the directive

set forth in my Advance Directive on _____
(Date - month/day/year)

Signature of Declarant (Patient) Date

Witness: This revocation has been voluntarily signed in my presence:

Signature of Witness Address Date

Signature of Witness Address Date

OPTIONAL: Complete only if the patient is unable to sign and the revocation was communicated to a third party.



I, _____, personally witnessed on _____
(Signature of witness to patient's communication to Revoke) Date

the communication of _____'s intent to revoke his/her Living Will/Durable Healthcare Power of Attorney/other form of Advance Health Care Directive.

Signature of other witnesses to patient's communication of intent to revoke Advance Directive.

Signed: _____ Date: _____

Signed: _____ Date: _____

***This is a legal document which is to be filed in the patient's medical record.
DO NOT DESTROY. FILE IN FRONT OF THE MEDICAL RECORD.***

Print Declarant's Name Date of Birth MR#

Address SS#

