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How to Revoke Your California Advance Health Care Directive

Revocation under California Probate Code Section 4695

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR REVOCATION OF ADVANCE HEALTH CARE DIRECTIVE.

About this form. Use this form to cancel an Advance Health Care Directive (or power of attorney for health care) you signed earlier, to remove your health care agent, or to cancel only part of your instructions. It does **not** cancel a financial power of attorney — that has its own revocation form. You can type into this form on your computer and then print it, but sign it by hand.

1. **Identify yourself and the old directive (Sections 1–2)**
   Enter your name, date of birth, and address so providers can match the revocation to your records, then the date of the old directive and the agent(s) named in it.
2. **Choose what you are revoking (Section 3)**
   Mark (a) to cancel everything, (b) to remove only your agent and keep your instructions, or (c) to cancel only certain parts. To remove an agent, California requires a signed writing (like this form) or telling your supervising health care provider in person.
3. **Sign and date it (Section 5)**
   Your signature makes the revocation effective. Sign in front of the notary or your witnesses.
4. **Have it notarized (recommended)**
   A notarized revocation is clear, official proof that you signed it and when — important if a hospital, family member, or former agent questions it later. Bring a current government-issued photo ID and do **not** sign ahead of time. Two adult witnesses are an alternative.
5. **Replacing your directive?**
   Sign the new Advance Health Care Directive at the same appointment. A newer directive also overrides an older one to the extent they conflict, but a written revocation removes any doubt.
6. **Give copies to everyone who had the old one**
   Your agent, doctors, hospital, and any care facility should each get a copy. Use the Distribution Record at the end of this packet to keep track.

After It's Signed

- Ask your doctor and any hospital or care facility to place the revocation in your medical record.
- If the old directive was registered with the California Secretary of State, update or remove the registration.
- Destroy your copies of the old directive, or mark them "REVOKED" with the date, so they are not used by mistake.

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SCAN TO BOOK

Questions about this document? Talk to an attorney. Gavrilov & Brooks Law Firm has attorneys licensed in California, Nevada, and other states. Phone and video consultations are available. **(916) 504-0529** · **www.gavrilovlaw.com**

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REVOCATION OF ADVANCE HEALTH CARE DIRECTIVE

(California Probate Code Section 4695)

1. PRINCIPAL

I, the undersigned principal, make this revocation while I have the capacity to do so.

_____ _____
(full legal name) (date of birth)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____
(phone)

2. DIRECTIVE BEING REVOKED

The advance health care directive (or power of attorney for health care) I am revoking (the "Directive") is identified as follows:

_____ _____
(date the Directive was signed) (name of agent named in the Directive)

_____
(name(s) of any alternate agent(s) named in the Directive)

☐ The Directive is registered with the California Secretary of State's Advance Health Care Directive Registry.

_____
(registry file number, if known)

3. WHAT I REVOKE (mark one)

☐ **(a) The entire Directive.** I revoke the Directive in its entirety, including the designation of every agent and alternate agent and all of my instructions for health care.

☐ **(b) Agent designation only.** I revoke the designation of the following agent(s). The rest of the Directive, including my instructions for health care, remains in effect.

_____
(name(s) of agent(s) whose designation is revoked)

☐ **(c) Part of the Directive only.** I revoke only the following part(s) of the Directive. The rest of the Directive remains in effect.

_____
(part(s) or section(s) revoked, e.g., "Part 2, Section 2.1")

4. EFFECT AND NOTICE

This revocation is effective immediately upon my signing it. I direct my health care providers to place a copy of this revocation in my health care records. Any health care provider, agent, conservator, or surrogate who is informed of this revocation should promptly communicate it to my supervising health care provider and to any health care institution where I am receiving care.

This revocation applies only to the Directive identified above. It does not revoke any power of attorney for financial matters that I have signed.

☐ I have signed a new advance health care directive, dated:

_____
(date of new directive)

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5. SIGNATURE

Signed this _____ day of _____ , 20 ____ , at _____
(city and state)

X _____ _____
(signature of principal) (printed name of principal)

WITNESSES

For proof that you signed this revocation, have your signature acknowledged before a notary public (next page) or signed in the presence of two adult witnesses below.

Each of us declares that the principal, who is personally known to us or whose identity was proven to us, signed this revocation in our presence and appeared to be of sound mind and under no duress, fraud, or undue influence.

Witness 1

_____
(signature)

_____
(printed name)

_____
(address)

_____
(date)

Witness 2

_____
(signature)

_____
(printed name)

_____
(address)

_____
(date)

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CERTIFICATE OF ACKNOWLEDGMENT

Notary acknowledgment of the principal's signature on this Revocation of Advance Health Care Directive.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California)

County of _____)

On _____ before me, _____

(here insert name and title of the officer)

personally appeared _____

, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

(Seal)

Signature _____

DISTRIBUTION RECORD

Keep this page — it is not part of your revocation. Give a copy of your signed revocation to everyone who has a copy of your old directive.

Given to	Name / contact	Date given
My agent		
Alternate agent(s)		
My primary physician		
Hospital / health system		
Care facility		
CA Secretary of State Registry		
Family member		
Other		
Other		
Other		

If your old directive was registered with the California Secretary of State, contact the Advance Health Care Directive Registry to update or remove the registration. Ask each provider to note the revocation in your medical record.

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