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How to Complete Your Illinois Revocation of Health Care Power of Attorney

Revocation of Health Care Power of Attorney or Living Will (755 ILCS 45/4-6 and 755 ILCS 35/5)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. Use this form to cancel an Illinois power of attorney for health care, a living will declaration, or both, so your doctors and former agents know the old document no longer applies.

1. **Identify the documents (Page 1)**
   Check each document you are revoking and enter its date and the name of any agent named in it.
2. **Sign and date (Page 1)**
   Illinois lets you revoke these documents at any time. A signed and notarized revocation gives clear proof of the date and your identity if anyone later questions it. Bring a current, government-issued photo ID.
3. **Notify your doctors and agents (Page 2)**
   Give a copy to your doctor, hospital, and each agent named in the old document, and record each notice on Page 2.

After It's Signed

- If you chose a 30-day delayed revocation in your Illinois health care power of attorney, that delay still applies. Your agent may keep acting during the 30 days.
- To revoke a Declaration for Mental Health Treatment, use the revocation on that form, which must also be signed by a physician.
- If you want new instructions, sign a new Illinois Power of Attorney for Health Care or Living Will Declaration. We have free forms for both.

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Have questions about this document? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**.

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REVOCATION OF HEALTH CARE POWER OF ATTORNEY AND LIVING WILL

(755 ILCS 45/4-6 and 755 ILCS 35/5)

I,

Full legal name

Date of birth

Address (street, city, state, ZIP)

revoke the following document(s) that I previously signed (check each that applies):

Power of Attorney for Health Care

Date signed

Name(s) of agent and successor agents whose authority is revoked

Living Will Declaration

Date signed

Other health care advance directive (not a Declaration for Mental Health Treatment)

Date signed

Description

I intend that the document(s) checked above have no further force or effect, subject only to any delayed revocation period I elected in my power of attorney for health care. I ask my physicians and health care providers to note this revocation in my medical records, and I direct each agent named in the revoked document(s) to stop acting for me.

Principal's initials: _____

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SIGNATURE

Date

X

Signature

Printed name

NOTARY ACKNOWLEDGMENT

STATE OF ILLINOIS)
COUNTY OF) SS.

This instrument was acknowledged before me on

(date)

by (name of signer)

X

Notary Public

Notary's printed name

My commission expires

(Notary seal)

RECORD OF NOTICE OF REVOCATION

A copy of this revocation was delivered to the following physician(s), health care provider(s), and agent(s):

Name of physician, provider, or agent	Method (hand, mail, email)	Date delivered
Name of physician, provider, or agent	Method (hand, mail, email)	Date delivered
Name of physician, provider, or agent	Method (hand, mail, email)	Date delivered
Name of physician, provider, or agent	Method (hand, mail, email)	Date delivered

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