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# How to Revoke a Pennsylvania Advance Directive

Revocation of Health Care Power of Attorney, Living Will, or Mental Health Directive

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

**About this form.** Use this form to cancel all or part of a health care power of attorney, living will, or mental health advance directive. A written, notarized revocation leaves a clear record for hospitals and family.

1. **Check what you are revoking**
   List each document and its date. You may revoke all or only part.
2. **List who gets a copy**
   Your doctors, hospital, former agent and family.
3. **Sign it, with a witness and notary if possible**
   Bring a current photo ID.
4. **Tell your doctor**
   A revocation takes effect when your physician or provider is told about it.

**Signing requirements:** Signed by you. A witness and notarization are recommended so the revocation is clearly documented.

## After It's Signed

- If you want new instructions or a new agent, sign a new advance directive.

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

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# REVOCATION OF ADVANCE HEALTH CARE DIRECTIVE

Commonwealth of Pennsylvania • 20 Pa.C.S. Chapters 54 and 58

Full name

Date of birth

Address

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

☐ Health care power of attorney dated:

Date

Agent named

☐ Living will / declaration dated:

Date

☐ Combined health care power of attorney and living will dated:

Date

☐ Mental health declaration and/or mental health power of attorney dated:

Date

☐ All advance health care directives I have previously signed.

☐ Only the following part(s) of the document(s) above:

This revocation takes effect when it is communicated to my attending physician or other health care provider by me or by a witness to this revocation. I ask that it be placed in my medical record. Any agent named in a revoked document no longer has authority to act for me.

I am delivering copies of this revocation to:

Physician(s), facilities, agents and family

X

Signature

Date

**WITNESS (optional)**

X

Witness signature

Date

Witness printed name

Address



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## ACKNOWLEDGMENT

**COMMONWEALTH OF PENNSYLVANIA**

**COUNTY OF** _____

This record was acknowledged before me on _____ (date) by _____ (name(s) of individual(s)).

**X** _____
Signature of notarial officer

_____
Title of office (e.g., Notary Public)

_____ _____
My commission expires Commission number

(Notary seal)



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