

▫ Revocation of enduring power of attorney (medical treatment)

Print the full name of your attorney here

To _____

Print your full name here

I _____

revoke the power of attorney (medical treatment) dated the _____

Print the date of the power of attorney document here

day of _____ 20 _____ that I gave you.

Sign your name here

Signed by _____

Print the full name of your witness here

Witnessed by _____

Witness signs and dates

Signature _____ Date _____