REVOCATION OF MEDICAL CONSENT AUTHORIZATION FOR MINOR CHILDREN

To:\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Child’s Medical/Mental Health Care/Insurance Provider/Medical Consent Designee

I hereby notify you in writing that I **revoke** the Medical Consent Authorization for Minor Children that I executed on \_\_\_\_\_\_\_\_\_\_\_\_\_, conferring upon ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, residing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the power to consent to necessary medical or mental health treatment for the following child(ren):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, residing at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Birthdate of Child(ren)

Address of Child(ren)

Name of Child(ren)

Address of Medical Consent Designee

Date of Signing

Name of Medical Consent Designee

The aforementioned Medical Consent Authorization for Minor Children is no longer in effect as of this date.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Legal Guardian/Custodian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent/Legal Guardian/Custodian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date