REVOCATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, Declarant, executed a Durable Power of Attorney for Health Care on the _____ day of _____, 20____, appointing _____ _____ as my attorney in fact to make health care decisions for me.

Ohio Revised Code § 1337.17 provides that I may revoke this Durable Power of Attorney for Health Care at any time and in any manner.

This is my written revocation of my Durable Power of Attorney for Health Care and is provided to all persons to whom I have provided a copy of my Durable Power of Attorney, including the person I appointed as my attorney in fact.

DATED this the _____ day of _____, 20____.

Signature of Declarant:

_____

Printed Name of Declarant:

_____

Address of Declarant:

_____

CERTIFICATE OF ACKNOWLEDGMENT

STATE OF OHIO

COUNTY OF _____

Personally appeared before me, a Notary Public in and for the County and State above named, _____,

personally known to me or who proved his/her identity to my satisfaction, who acknowledged that he/she signed the above and foregoing Power of Attorney.

This is the _____ day of _____, 20_____.

_____

Notary Public

My Commission expires: _____