LAMPREY HEALTH CARE

Where Excellence and Caring go Hand in Hand

Cancelation of Personal Representative

Patient Name: _____ DOB: _____

I hereby cancel my previous designation of Personal Representative. I request that this person be removed from my medical record as my Personal Representative immediately.

Name of Representative to be removed: _____

Relationship to Patient: _____

Signature of Patient or Legal Guardian: _____ Date: _____

Print Name of Patient or Parent/Legal Guardian: _____

Relationship to Patient: _____