SECRETARY OF THE STATE OF NORTH CAROLINA

Advance Health Care Directive Registry
P.O. Box 29622
Raleigh, NC 27626-0622
Website: https://www.sosn/gov

REMOVAL FORM

Please complete the information listed below in order to withdraw your health care directive information from our database. When completed, YOUR SIGNATURE MUST BE NOTARIZED BY A COMMISSIONED NOTARY.

Please delete my documents from the Advance Health Care Directive Registry.

1. **Registrant's Full Name: ____**
2. **Registrant's File Number: ____**
3. **Check the health care directives that you wish to remove from the registry.**

- ☐ **A health care power of attorney;**
- ☐ **Advance directive for a natural death (living will);**
- ☐ **An advance instruction for mental health treatment; or**
- ☐ **A declaration of an anatomical gift.**

I understand that the deletion of these records from the registry does not 1) affect the validity of the document(s) in whole or in part, 2) relate to the accuracy of the information contained in the document(s), and 3) create a presumption regarding the validity of the document, regarding the accuracy of information contained in the document(s) or that the statutory requirements for the document(s) have been met.

Registrant's Signature: ____

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STATE OF __________________

SEAL

COUNTY OF ________________

Signed and sworn to (or affirmed) before me this day by _____________________________.
Name of Declarant

Witness my hand and official seal, this the _____ day of ____________, 20_______.

____
Official Signature of Notary

______________________________, Notary
Notary's printed or typed name
My commission expires:_______________