REVOCATION

I, (NAME AND TWO SURNAMES OF THE PATIENT), OF _____ YEARS OF AGE,

WITH ADDRESS AT _____ AND NATIONAL IDENTITY DOCUMENT NUMBER _____

I, (NAME AND TWO SURNAMES) OF _____ YEARS OF AGE,
WITH ADDRESS AT _____
AND NATIONAL IDENTITY DOCUMENT NUMBER _____,

IN MY CAPACITY AS _____
(LAWFUL ATTORNEY, RELATION OR CLOSE FRIEND) OF _____
(NAME AND TWO SURNAMES OF THE PATIENT)

Revoke the consent granted on the …… and do not wish to continue the treatment, which I consider terminated as of this day.

At _____ (PLACE AND DATE)

Signed: THE DOCTOR Signed: THE PATIENT Signed: THE LAWFUL ATTORNEY