HEALTHCARE PERSPECTIVE

SUPPLEMENT

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A Sample Informed Refusal of Care Form for Healthcare Business Owners

Patient name: _____ Date: _____

ID#: _____ Date of Birth: _____

This is to certify that I, (*Patient Name*) _____,

a patient at (*Healthcare Business*) _____,

am knowingly refusing treatment against the medical advice of (*Provider Name*) _____.

I am refusing the following:

☐ **Medical Examination**
I have made the decision to leave prior to being examined by a healthcare provider.

☐ **Continuation of Care After Medical Screen**
I understand that I do not have an emergency medical condition and acknowledge that I have not been refused treatment.

☐ **Test or Treatment**
I am refusing to undergo the following tests and/or treatments: _____
and the risks of doing so have been explained to me.

☐ **Remaining in the Facility**
I refuse further care and am leaving the facility against the advice of my provider.

☐ **Other** _____

I understand that my refusal of treatment and care has been documented in my medical record. I have been informed of the risks involved, including a possible worsening of my medical condition. I assume all risks of this refusal and release my treating providers from all responsibility and liability for any ill effects that may result from such refusal of treatment and care.

Patient signature: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____

I declare that I have personally explained to the patient the risks and potential consequences of his/her decision, described the benefits of treatment and presented alternative therapeutic possibilities, if any exist.

Provider: _____ Date: _____

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