Provider to complete:

The following medical treatment is being recommended by the Provider:

_____

_____

_____

The provider has reviewed the benefits, any alternative treatment, and the following potential risks that could result from declining treatment:

_____

_____

_____

Risks may include, but are not limited to death, additional pain/suffering, permanent disability/disfigurement.

I have read this document and have been given the opportunity to ask questions and my questions have been answered to my satisfaction.

I decline recommended medical treatment and assume all responsibility for doing so.

I release the Hospital, it's administration, all personnel, and providers (including physicians) from any responsibilities for all consequences, which may result from declining treatment.

_____
Patient/Legal Guardian Print Name

_____ _____
Patient/Legal Guardian Signature Date/Time

_____ _____
Provider Signature Date/Time

❑ The above has been explained to the patient, he/she refuses to sign this form

_____ _____
Provider Signature Date/Time