Refusal to Permit Medical Treatment

PATIENT _____ AGE _____

I have been advised and it has been recommended by my physician Dr. _____ that I, or a person for whom I am the legal guardian, undergo the following test(s), treatment(s), operation(s) or procedure(s):

_____

_____

_____

My physician has satisfactorily explained the above test(s), treatment(s), operation(s) or procedure(s) to me, the risks and benefits of this recommendation, the alternatives to this recommendation and the probable consequences of not receiving the test(s), treatment(s), operation(s) or procedure(s). In addition, I have had the opportunity to ask questions about the proposed recommendation and have had these answered to my satisfaction.

Notwithstanding the recommendation of my physician and with the knowledge I have regarding this recommendation, I have decided NOT to accept/permit the test(s), treatment(s), operation(s) or procedure(s) listed above. I understand that my failure to follow my physician's advice may seriously affect my health or the health of the person under my guardianship.

By signing below, I assume responsibility for all the risks and consequences of my refusal. I also release Dr. _____ and other persons participating in my care or that of the person under my guardianship from all responsibility for any unfavorable or bad results that may occur as a result of my refusal to accept/permit the proposed recommendation.

_____	_____	_____
Patient/Guardian	Date	Time
_____	_____	
Witness	If signed by other than patient, indicate relationship	