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