Frontera Healthcare Network

REFUSAL TO PERMIT MEDICAL TREATMENT OR SERVICES

I hereby acknowledge that my healthcare provider, _____, has informed me of the nature and advisability of the risks and complications inherent in, the expected benefits of, the alternatives to (and their risks and benefits), and the probable consequences of not receiving the following medical treatment or services: _____

_____

_____

Notwithstanding the recommendation of my healthcare provider, I hereby request that the foregoing treatment or services not be administered to me during my stay at _____(Center); and I hereby release the center, its Board of Directors, my healthcare provider, employees, personnel, independent contractors, agents, representatives, and other persons participating in my care and treatment from any responsibility or liability whatsoever for unfavorable or untoward results which I understand may occur as a result of my refusal to permit this medical treatment or services.

By: _____

[Signature of Patient/Legal Representative]

Print Name: _____

Date/Time: _____ A.M./P.M.

If signed by other than Patient, indicate relationship: _____

By: _____

[Signature of Witness]

Print Name of Witness: _____

Date/Time: _____ A.M./P.M.

Interpreter/Translator to complete when applicable:

I have accurately and completely read/translated the foregoing document to:

_____

[Insert the Patient's or Patient's Legal Representative's Name]

in _____, the Patient's or Patient's Legal Representative's primary language. S/He understood all of the terms and conditions and acknowledged his/her agreement and consent thereto by signing the document in my presence.

Interpreted/Translated By: _____

[Signature of Interpreted/Translator]

Print Name of Interpreter/Translator: _____

Date/Time: _____ A.M./P.M.