Patient Name: ___________________________SCCHC Medical Record #:____________________DOB:_______________

Patient Informed Refusal for Medical or Surgical Procedures/Treatment Recommended by SCCHC Providers

You have been given information about your condition and the recommended surgical, medical or diagnostic procedure(s) to be used. This **Patient Informed Refusal Form** is designed to provide a written confirmation as well as a documentation of your informed refusal to the recommended treatment and/or procedures.

My physician/provider, __________________________________ has recommended the following test/procedure/treatment (including alternatives): ____
____.

My physician/provider has explained to me that the potential benefits of the test/procedure/treatment include: _______
____
____.

And that the risk(s) include:____
____
____.

The physician/provider has explained the following risk(s) to my refusal. They include, but are not limited to the test/treatment of the above recommended:
____
____
____.

By signing this document, I acknowledge that (1) my medical condition has been evaluated and explained by my physician/provider, who has recommended treatment as stated above, (2) that the physician/provider has explained to me the potential benefits of such treatment and the risks associated with it, (3) the physician/provider has explained to me the possible risks of not following the recommended treatment, which I fully understand, and (4) I have had an opportunity to discuss any and all questions related to the recommended treatment.

In spite of statement above, I refuse or decline to consent to this medical treatment. My reason(s) for refusing is (are):
____
____
____.

_____________________	________________________________	____________________________
Date & Time	(Signature of patient or authorized individual)	(Relationship of authorized individual)

- ☐ The patient/authorized individual has read this form or had it read to him/her.
- ☐ The patient/authorized individual states that he/she understands this information.
- ☐ The patient/authorized individual has no further questions.
- ☐ The patient/authorized individual refuses to sign this form.

_____________________	________________________________	____________________________
Date & Time	(Signature of witness)	(Title of Witness: physician/provider/other)

June, 2014