Medical Treatment Refusal Waiver

I,

_____

, hereby acknowledge that I have been offered medical treatment by

_____

on

_____

.

I understand the risks involved in refusing the recommended treatment, including but not limited to potential worsening of my condition or other complications.

I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I acknowledge that I am refusing the recommended treatment voluntarily and at my own risk.

Date of Refusal:

_____

Patient Name:

_____

Signature:

_____

Witness Name:

_____

Signature:

_____

Healthcare Provider Name:

_____

Signature:

_____

Additional Comments (optional):

_____