

Informed Refusal Form

Patient's Name _____ DOB _____

1. My provider, _____, has recommended the following test/procedure/treatment: _____.

2. He/she explained to me:

- the potential benefits of this test/procedure/treatment which include:
- the risks of the test/procedure/treatment which include:
- the alternatives to the test/procedure/treatment which include:

3. My provider has explained the following risks and adverse consequences of **my refusal** of the test/procedure/treatment. These include, but are not limited to:

4. My reason for refusal is:

5. By signing this document, I acknowledge that my provider has clearly explained my medical condition and the recommended treatment (above) including the risks and benefits of such treatment and has answered all of my questions.

I acknowledge that my provider has also explained the risks and consequences of my refusal of the test/procedure/treatment and has answered all of my questions.

Despite my provider's recommendation, I refuse to consent to this test/procedure/treatment.

Date/Time

Signature of Patient or Authorized Individual

Relationship of Authorized Individual to Patient

6. I have explained to the Patient/Authorized Individual the risks, benefits and alternatives of the proposed course of action as well as the risks and consequences of not following the advised course of action. The Patient/Authorized Individual has been given the opportunity to ask questions and I have answered these questions.

Date/Time

Signature of Provider

DISCLAIMER: This form is offered as reference information only and is not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.