SAMPLE REFUSAL OF TREATMENT

I, ______________, refuse to consent to the following treatment/procedure/diagnostic test/medication/referral as recommended by my physician, ______________ M.D./D.O.:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

______________________________
Dr. _______________ has explained the recommended treatment, the benefits and risks involved, the possible alternatives to the treatment, and the consequences of my refusal to my health and well-being, and I understand all of this information.

Dr. _______________ has given me the opportunity to ask questions, and the doctor has answered my questions about the proposed treatment.

I understand that my refusal is against the medical advice of my doctor.

______________________________                  ___________________________
(Patient’s Signature)                (Date)

_____________________________         ___________________________
(Physician’s Signature)             (Date)

_____________________________         ___________________________
(Witness Signature)                         (Date)