McLaren Medical Group

REFUSAL OF MEDICAL CARE, TREATMENT, AND/OR TRANSPORTATION

Patient's Name: _____**DOB:** _____

I understand that complications to my general health may occur if I do not proceed with the recommended

treatment. My provider has recommended the following to me: _____

Acknowledgment

I have received information about the proposed treatment. I have discussed my treatment with my provider and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, the alternate treatment options, and the risks of the recommended treatment, and my refusal of care.

I personally assume the risks and consequences of my refusal, and release the provider and McLaren Medical Group from any or all liability for ill effects which may result from my refusal to consent to the performance of the proposed treatment.

I have been advised that medical care on my behalf is necessary, and that refusal of care and assistance could be hazardous to my health, and under certain circumstances, include disability or death.

I acknowledge that I may have a medical problem which may require additional medical attention, and that an ambulance is available to transport me to the hospital. Instead, I elect to seek alternative medical care and refuse further evaluation, treatment and transport.

I acknowledge that I have read this document in its entirety

I Do NOT wish to proceed with the recommended treatment against the advice of the provider.

Signed: _____Date: _____
Patient or Guardian

Signed: _____Date: _____
Provider

***FOR MINORS OR PERSONS WHO HAVE GUARDIANS*:** I am the patient's legal guardian.

My relationship to the patient is _____. I am hereby acting on behalf on the **patient**.

I have read the above information and refuse medical care, treatment and/or transportation on behalf of the patient.

Guardian's Signature: _____ Date: _____

Guardian's Name (**print**): _____Guardian's Full Address & Phone No: _____

If you change your mind or your condition changes, call 911 and go to the nearest hospital emergency room.

Patient Name:

Date of Birth: