INFORMED TREATMENT REFUSAL

Dr.________________________ has advised me that the following treatment needs to be performed:

____

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I have had a discussion with **Dr.________________________** regarding the risks, benefits, and alternatives of this treatment as well as the consequences of not proceeding, and I have had the opportunity to ask him/her any questions I have regarding my concerns about the treatment. All of my questions have been answered to my satisfaction, so that I can confirm that I do not want the treatment.

I release **Dr.________________________** from any liability for any ill effects that I may suffer from failure to perform the treatment proposed to me.

I understand the nature, purpose, benefits, and alternatives to the proposed treatment, as well as the risks and consequences of proceeding or not proceeding with the treatment.

My signature below signifies that all questions have been answered to my satisfaction regarding this consent and I fully understand the risks involved in the proposed treatment and/or surgery. I certify that I speak, read, and write English.

Patient's Name __________________________Doctors Signature ________________

Signature of Patient _____________________________________Date ____________