FORM 4-5

Release From Responsibility For Treatment of Miscarriage or Partial Abortion

I, the undersigned, a patient at *(hospital name)* _____
_____, am advised by my doctor that I may be in a condition of abortion. I hereby declare that neither the physician(s) nor any person employed by or connected with this hospital has performed any act which may have contributed to the interruption of my pregnancy. I do hereby absolve this hospital, the treating physician(s), and any other person participating in my care from responsibility for my condition.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient)

Print name: _____

THIS FORM MAY BE COMPLETED IN THE CASE OF PATIENTS WHO ARE OR *MAY BE* IN A CONDITION OF ABORTION UPON ARRIVAL AT THE HOSPITAL.

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

FORM 4-5S

Exencion de Responsabilidad por el Tratamiento del Aborto Espontáneo o Aborto Parcial

Yo, la paciente en el *(indique el nombre del hospital)* _____ _____ que suscribe, declaro que mi médico me ha informado de la posibilidad de que esté por abortar. Afirmo por la presente que ni el médico ni ninguna otra persona empleada por este hospital o relacionada con el hospital ha realizado ningún acto que podría haber contribuido a la interrupción de mi embarazo. Por la presente, absuelvo a este hospital, al médico(s) del caso, y a cualquier otra persona que haya participado en mi caso de toda responsabilidad por mi condición.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente)

Nombre en letra de imprenta: _____
(paciente)

THIS FORM MAY BE COMPLETED IN THE CASE OF PATIENTS WHO ARE OR *MAY BE* IN A CONDITION OF ABORTION UPON ARRIVAL AT THE HOSPITAL.

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)