FORM 9-6

Patient Refusal of Further Medical Treatment

I acknowledge that I have been examined and that I have been offered further examination and treatment at *(hospital name)* _____. However, I refuse further medical examination and treatment. I have been informed of the risks and consequences potentially involved in this refusal, the possible benefits of continuing medical treatment at this hospital, and any alternatives to my decision to refuse further examination and treatment.

I hereby release the attending physician, any other physicians involved in my care, the hospital, and its agents and employees, from all responsibility for any ill effects which may result from my refusal of further medical examination and treatment.

I understand that the physicians involved in my care are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

COPY MUST BE GIVEN TO PATIENT.

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

Reference: 42 U.S.C. Section 1395dd(b)(3)

FORM 9-6S

Rechazo por Parte del Paciente de Tratamiento Medico Adicional

Reconozco que he sido examinado y que me han ofrecido un examen y tratamiento adicionales en este hospital *(nombre de hospital)* _____. Sin embargo, rehúso dicho examen y tratamiento médico adicionales. Se me ha informado acerca de los riesgos y posibles consecuencias de mi rechazo, de los posibles beneficios de continuar el tratamiento médico en este hospital y cualquier alternativa a mi decisión de rechazar el examen y tratamiento adicionales.

Por medio del presente exonero al médico del caso, a cualquier otro médico involucrado en mi atención médica, al hospital y a sus agentes y empleados, de toda responsabilidad por cualquier efecto adverso que pueda resultar de mi rechazo de un examen y tratamiento médico adicionales.

Entiendo que el médico que me atiende y otros médicos que me brindan servicios no son empleados ni agentes del hospital. Son médicos facultativos independientes.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

COPY MUST BE GIVEN TO PATIENT.

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

Reference: 42 U.S.C. Section 1395dd(b)(3)