**FORM 5-1**

# Refusal to Permit Medical Treatment

My doctor *(physician name)* _____,

has advised the following medical treatment: _____

_____

My doctor has informed me of the following:

1. The nature and advisability of this medical treatment.
2. The risks and complications of this medical treatment.
3. The expected benefits of this medical treatment.
4. The alternatives to this medical treatment and their risks and benefits.
5. The probable consequences of not receiving this medical treatment.

I understand that the doctor named above and other doctors who provide services to me are not employees or agents of the hospital. They are independent medical practitioners.

Notwithstanding the recommendation of my doctor, I hereby request that this medical treatment not be administered to me during my stay at *(name of hospital)* _____ .

I hereby release the hospital, its personnel, my doctor, and any other persons participating in my care from any responsibility whatsoever for any injury or unfavorable consequences which may occur as a result of my refusal to permit this medical treatment.

Date: _____ Time: _____ AM / PM

Signature: _____
*(patient/legal representative)*

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

Print name: _____
*(legal representative)*

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

**FORM 5-1S**

# Negativa a Permitir Tratamiento Médico

Mi médico *(nombre del médico)* _____ ha aconsejado el siguiente tratamiento médico: _____

_____

Mi médico me ha informado lo siguiente:

1. La naturaleza y la conveniencia de este tratamiento médico.
2. Los riesgos y las complicaciones de este tratamiento médico.
3. Los beneficios que se esperan de este tratamiento médico.
4. Las alternativas a este tratamiento médico y sus riesgos y beneficios.
5. Las consecuencias probables de no recibir este tratamiento médico.

Entiendo que el médico antes nombrado y otros médicos que me prestan servicios no son empleados ni agentes del hospital, son médicos independientes.

Sin perjuicio de la recomendación de mi médico, por la presente, solicito que no se me administre este tratamiento médico durante mi permanencia en el *(nombre del hospital)* _____ .

Por la presente eximo al hospital, a su personal, a mi médico y a otras personas que participen en mi atención de toda responsabilidad, sea cual fuere, por cualquier lesión o consecuencia adversa que se pueda producir debido a mi negativa a permitir este tratamiento médico.

Fecha: _____ Hora: _____
AM / PM

Firma: _____
*(paciente/representante legal)*

En caso de que lo firmase una persona que no sea el paciente, indique la relación: _____

Nombre en letra de imprenta: _____
*(representante legal)*

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