

**REFUSAL TO CONSENT AND RELEASE**

Consent-E  
Refusal to Consent and Release



IDN13150170

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

**Place Patient Label**

1. I have been advised by my physician, Dr. \_\_\_\_\_  
that the following procedure(s)/treatment(s) should be performed upon me:

\_\_\_\_\_  
*procedure(s)/treatment(s)*

- 2. My physician has explained to me, and I understand the following:
  - A. The nature of the recommended procedure(s)/treatment(s).
  - B. The purpose of and need for the recommended procedure(s)/treatment(s).
  - C. The possible alternatives to the recommended procedure(s)/treatment(s) for which I similarly refuse consent.
  - D. The probable consequences of not proceeding with the recommended procedure(s)/treatment(s) and/or alternatives.

3. I know that my failure to follow my physician's recommendations will endanger my life or health. I nonetheless refuse to consent to the proposed procedure(s)/treatment(s).

4. My reason for refusal is: \_\_\_\_\_  
\_\_\_\_\_

5. I personally assume the risks and consequences of my refusal, and release myself, my heirs, executors, administrators, or personal representatives, the physicians who have been consulted in my case and Rush University Medical Center, its officers, agents, and employees from any and all liability for ill effects which may result from my refusal to consent to the performance of the proposed procedure(s)/treatment(s).

6. I acknowledge that I have read this document in its entirety and that I fully understand it.

**CAUTION -- THIS IS A RELEASE OF LIABILITY -- READ BEFORE SIGNING**

DATE: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Refusing Party*

TIME: \_\_\_\_\_ A.M. / P.M.

**WITNESS:**

**IF REFUSING PARTY IS OTHER THAN PATIENT:**

\_\_\_\_\_  
*Signature of Witness*

\_\_\_\_\_  
*Signature of Refusing Party*

\_\_\_\_\_  
*Relationship*

**(See reverse side for instructions)**

RUSH UNIVERSITY MEDICAL CENTER  
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**Place Patient Label**

**INSTRUCTIONS:** This refusal to consent form should be signed by the patient or authorized party if he/she refuses any surgical procedure or medical treatment recommended by his/her physician. If the patient or authorized party not only refuses the procedure(s)/treatment(s) but also refuses to sign this form the following should be completed.

\_\_\_\_\_ was provided the information  
*Name of Refusing Party*

referred to in paragraph 2 on the reverse side but nevertheless refused to consent to the recommended procedure(s)/treatment(s) referred to in paragraph 1 on the reverse side and furthermore refused to sign this form documenting his/her refusal.

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_ A.M. / P.M.

\_\_\_\_\_  
*Signature of Person Receiving Refusal*