REFUSAL TO PERMIT MEDICAL TREATMENT

I, (print name)____________________________ hereby acknowledge that my healthcare provider has informed me of the advisability, risks and benefits of (name of procedure) ______________________. Having been fully informed of the possible consequences of not receiving this treatment, I hereby release the University of California, the UCSC Student Health Center and its staff from any responsibility whatsoever for unfavorable results which may occur as a result of my refusal to permit this medical treatment.

The possible consequences of failure to receive this treatment include

________________________________________________________________________

________________________________________________________________________

(Clinician sign and date)

________________________________________________________________________

I have read and understand the above information and refuse to accept this treatment.

(Patient sign and date)