

# Refusal of Medical Treatment Acknowledgment

I, , hereby acknowledge that I have been informed by  regarding the recommended medical treatment for my condition.

I understand the nature of my condition and the proposed treatment, including the potential benefits and risks associated with both accepting and refusing the treatment.

I have had the opportunity to ask questions and have had my questions answered to my satisfaction. I am aware that by refusing the recommended care, there may be risks, including a worsening of my condition or other adverse consequences.

I acknowledge that despite understanding these risks, I am choosing to refuse the recommended medical treatment.

Patient's Signature:  Date:

Witness's Signature:  Date: