NAVAL HEALTH CLINIC CORPUS CHRISTI

RELEASE FROM RESPONSIBILITY

1. I have willfully chosen to leave / refuse care from Naval Health Clinic Corpus Christi.

2. I acknowledge that I have been informed of potential risks involved with this decision as follows (Check all that apply):

☐ Condition may stay the same or worsen
☐ Increased pain
☐ Short, long-term, or permanent disability
☐ Delay of diagnosis/treatment to underlying condition
☐ Possible infection
☐ Death
☐ Other (specify): _____

3. I have been informed of the potential benefits of treatment as follows (check all that apply):

☐ Condition improvement
☐ Diagnostic and/or therapeutic intervention
☐ Referral, as warranted
☐ Unanticipated complications may be prevented
☐ Transfer to appropriate facility
☐ Other (specify): _____

4. Description of Examination and/or treatment refused (check all that apply):

☐ Medical/Dental examination
☐ Medication Administration
☐ Invasive procedure
☐ Diagnostic testing (i.e., Laboratory, Radiology, etc.)
☐ Intravenous therapy
☐Transfer to appropriate facility
☐ Other (specify): _____

5. Reason(s) for refusal:

☐ Symptoms resolved ☐ Desires second opinion ☐ Patient refused to explain (or left without notification)
☐ Other (specify): _____

6. Steps taken to secure informed consent (check all that apply):

☐ Paged patient to area ☐ Explained risks/benefits ☐ Notified provider
☐ Provider talked with patient/family ☐ Other (specify): _____

7. Despite the recommendation of the health care provider, I refuse to consent to the medical/dental care, as indicated above. By signing this document, I acknowledge that I have been provided the information necessary to participate fully in this decision making process and hereby release the health care provider, Naval Health Clinic Corpus Christi, and the United States Government of responsibility from any liability which may result from my decision. I fully understand what was discussed with me and accept the responsibility for this refusal and the consequences that may result from this decision.

_____ _____ _____
Date/Time: Signature of Patient (or authorized individual) Relationship to patient

_____ _____
Witness: Date/Time: