

## SAMPLE REFUSAL OF TREATMENT

I, \_\_\_\_\_, refuse to consent to the following treatment/procedure/  
diagnostic test/medication/referral as recommended by my physician, \_\_\_\_\_  
M.D./D.O.:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dr. \_\_\_\_\_ has explained the recommended treatment, the benefits and risks  
involved, the possible alternatives to the treatment, and the consequences of my refusal to my  
health and well-being, and I understand all of this information.

Dr. \_\_\_\_\_ has given me the opportunity to ask questions, and the doctor has  
answered my questions about the proposed treatment.

I understand that my refusal is against the medical advice of my doctor.

\_\_\_\_\_  
(Patient's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Physician's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness Signature)

\_\_\_\_\_  
(Date)



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P.O. Box 9118, Des Moines, IA 50306

If you would like to discuss a particular situation, please  
contact our risk management division at 1-888-336-2642  
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