

EMPLOYEE WELLNESS, P.A.

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AGAINST MEDICAL ADVICE-AMA

PATIENT AUTHORIZATION AND NOTICE

Patient Name

Date

Time of Visit

Office Location

REFUSAL OF RECOMMENDED TREATMENT

Medical examination, treatment, or testing has been recommended for me. I have decided to reject further treatment or medical evaluation, and will leave the facility.

I am refusing medical care of my own choice, and contrary to the instructions and wishes of the above provider or physician. I understand that permanent harm or even death can occur from failing to follow the recommendations of the provider/physician.

Because I am refusing recommended medical care, I agree to absolve and release the provider/physician and the practice from any and all liabilities for damages arising from any current medical condition. I accept all risk associated with my medical condition both known and unknown.

I assume all responsibility for this action. I agree that I will make no claim of any nature against this facility of the doctor under any circumstances.

REFUSAL OF TREATMENT INCLUDING: *list treatment(s)*

SPORTS PHYSICAL - REFUSAL/REJECTION OF EKG

It is recommended that an EKG be performed on **any and all students participating in Sports Activity older than 15 years of age to clear them of any related cardiac issues.** I assume ALL responsibility and release the physician and the practice from any and all liabilities.

Signature of patient or guardian

Date

Signature of witness

Date