

## 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