



EMTALA
REFUSAL TO PERMIT FURTHER MEDICAL SCREENING
EXAMINATION AND TREATMENT FOR EMERGENCY
MEDICAL CONDITION
(SEND COPY WITH PATIENT)

I hereby acknowledge that a physician or qualified medical person has informed me of the nature of my medical condition and about the risks and complications that might arise if I do not receive further examination or treatment. He or she has also explained to me the risks and expected benefits of alternatives to further examination and treatment, as well as probable consequences of my not receiving further medical treatment for my emergency medical condition.

The Further examination and treatment recommended:

The expected benefits of the recommended examination and treatment:

The risks of not receiving the recommended examination or treatment:

I understand that if I do not receive this further medical examination and treatment, my health and life and, if I am pregnant and having contractions, the health and life of my unborn child, may be at risk. I also understand that [insert Hospital name] is obligated by federal law to provide me with further examination to the extent necessary to determine whether I have an emergency medical condition and with treatment necessary to stabilize any emergency medical condition within the hospital's capabilities regardless of whether I am able to pay for that examination or treatment or if I do not have insurance.

Notwithstanding the recommendation of the physician or qualified medical person. I hereby request the above treatment may not be administered to me at the hospital, and hereby release the hospital, its personnel, the physician, or any other persons participating in my care from any responsibility whatsoever for unfavorable or untoward results which I understand may occur as a consequence of my refusal to permit this medical treatment.

 Patient/Legally Responsible Person

 Date

 Relationship if other than the patient

 Print Witness Name

I have explained to the patient (or legally responsible person) the probable consequences of not receiving further medical examination and treatment for the Emergency Medical Condition.

 Physician/Qualified Medical Person Signature

 Date

 Time

 Physician Counter Signature, if applicable

 Date

 Time

 Primary Nurse Signature

 Date

 Time

 Interpreter Signature/ID#

 Date

 Time

NOTE: If the patient refuses to sign such a statement, he/she cannot be forced to do so nor may his/her release be withheld until he/she signs. If this occurs, the form should be filled out, witnessed by the hospital personnel present, and the statement written on the form **"Risks explained but signature refused."**