TREASURE COAST Primary Care

1980 SE Ocean Blvd. • Stuart, FL 34996 • **772-678-7043**
www.tcprimarycare.com | Secure Fax: 772-403-2379

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