Texas Tech University Health Science Center El Paso Ambulatory Clinic	Patient Name Medical Record # DOB (or label)

Refusal to Submit to Treatment and/or Refusal to Follow Provider's Instructions

Date: _____ **Time:** _____

I, _____ (Name of Person Giving Consent), (the _____ (Relationship if other than patient)

of, _____ (Patient Name), acknowledge that I have been informed

by, _____ of Texas Tech University Health Sciences Center El Paso that I am (he/she is) in need of medical treatment.

(State nature of treatment required, in lay terms)

The nature and effect of this treatment has been explained to me. I voluntarily refuse to submit to this recommended treatment at Texas Tech University Health Sciences Center El Paso and the risks and consequences to my (his/her) health have been explained to me.

I assume the risks and consequences involved and release the above named provider(s) and the Texas Tech University Health Sciences Center El Paso and its Staff from any liability or ill effects resulting from my actions.

_____
Signature of Patient or Person Authorized to Consent for Patient

_____
Witness