TurnKey HEALTH

WAIVER OF TREATMENT/EVALUATION

(Form must be completed in its entirety)

PATIENT Jason Lynch Date 7/30/24 Time _____

I certify that I am refusing to consent to the following treatment/procedure/diagnostic test/medication/outside referral/laboratory at my own insistence and against the advice of the health care provider.

1. Refusal for: AM Med Pass Vital Signs Detox Assessment PM Med Pass

Other: medical observation/housing related to multiple reports of health concerns

Reason for the refusal: Medical Autonomy-exercising right to refuse

Other:

2. I have been informed by a qualified healthcare professional of the risks attendant to my refusal. These include:

Risk of worsening of medical condition(s) that may even lead to death.

3. During the clinical interview which included counseling and education, the qualified healthcare professional has given me the opportunity to ask questions and has answered my questions.

4. I assume full responsibility for any results caused by my decision and I hereby release the institution, its employees, officers, and the provider from all legal responsibility and liability.

5. I certify that I am of sound mind and have read, or had read to me, and fully understand the above information concerning my refusal to accept treatment/evaluation and have had an opportunity to ask questions before I affix my signature.

6. I understand I may retract my decision and receive the treatment/procedure/diagnostic test/medication/outside referral/laboratory, although consequences due to the delay may result.

Jason M Lynch
Patient Signature Date

Heather Heeg, LPN 7/30/24
Qualified Healthcare Professional Date

Witness Date

If the patient refuses to sign such a statement, he/she cannot be forced to do so legally. If this occurs, the form should be filled out, witnessed by two facility personnel and the statement documented on the form, "SIGNATURE REFUSED".

REVISED 1/31/2023